WOUNDED HEALERS AND RELATIONAL EXPERTS: 
A GROUNDED THEORY OF EXPERIENCED PSYCHOTHERAPISTS’ 
MANAGEMENT AND USE OF COUNTERTRANSFERENCE

A Thesis in 
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by 
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ABSTRACT

“Wounded Healers and Relational Experts: A Grounded Theory of Experienced Psychotherapists’ Management and Use of Countertransference” is a qualitative exploration yielding a theory of how psychotherapists may encounter, engage, manage, and make useful their personal reactions to challenging clients. Twelve psychotherapists were nominated by peers and were interviewed for approximately one hour each about a case of their choosing in which therapeutic gains were made. The interviews were analyzed primarily through grounded theory procedures, incorporating some elements of Consensual Qualitative Research.

Ultimately the theory consisted of a core category, “therapist reactivity management,” that incorporated cognitive work, experiential change, responsiveness, and use of self. Therapist reactivity management was related to five other categories: causes of reactivity, reactivity, effects of reactivity, management facilitators, and management results.

The essence of the core category was the process of bringing therapist and client psychological needs into conscious relationship with each other. This definition captured the diversity of therapist experiences without reducing them down to a single pathway. Variations depended on therapist attitudes toward reactivity, degree of resolution of underlying issues, and the type and intensity of the challenge presented by the client. Two main approaches emerged: that of the wounded healer, and that of the relational expert. Results were integrated with existing literature and recommendations made for psychotherapist training and practice.

This study is the first qualitative investigation focused on countertransference management, and as such offers new possibilities for clinical application and understanding of a process recognized for nearly 100 years and crucial to helping troubled individuals through therapeutic relationship.
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Chapter I

INTRODUCTION

The effort to understand and inform psychotherapy practice through sound research has been plagued with methodological trade-offs, epistemological dilemmas, and gaps of attention (Hill, 1982). Nowhere are these problems more evident than in the area of countertransference (hereafter, CT) and its management. Psychotherapy research may be likened to a three-legged chair, unsteadily supported by investigations of therapy process, therapy outcome, and the client’s psychology. Investigation of the therapist’s psychological experience and its reciprocal relations with the other three aspects of psychotherapy would provide the missing leg, moving psychotherapy research further in the direction of theoretical coherence and clinical utility.

Freud must be credited for recognizing the impact the therapist’s personal issues can have on the therapy relationship and therapy outcome. In 1910, when Freud first introduced the term “counter-transference,” he was lecturing to a gathering of his own followers on the future of psychoanalysis. His emphasis was on the need for further advances in psychoanalytic knowledge, technique, and prestige. His treatment of the “patient’s influence on [the therapist’s] unconscious feelings” (p. 19) appears to manifest a tension between claims for psychoanalytic efficacy and the acknowledgement of therapists’ potential inadequacies. Far from recognizing the spectrum of CT management that is discussed today in psychodynamic theory, from active use to management to acting out, Freud portrayed CT management as a dichotomous phenomenon: either the therapist eradicates its influence through self-analysis, or “may without more ado regard himself [sic] as unable to treat neurotics by analysis” (p. 19). The field of
psychoanalysis has been struggling with this same tension between caveats about the dangers of CT, and explorations of its use and management, ever since.

Two developments have offered new hope for extending our awareness of CT: a shift in psychodynamic thinking toward acceptance and exploration of the therapist’s needs and conflicts in relation to those of the client, and the beginnings of research on CT and its management. The shift in thinking had early advocates among Freuds’ immediate disciples (Ferenczi, 1920), but it did not coalesce until the 1980s, when self psychologists (e.g., Atwood & Stolorow, 1984; Bacal, 1985) began writing about intersubjectivity as a paradigm through which to view all therapeutic activity.

In between its beginnings and its contemporary conceptualization, CT underwent another revision that nearly caused it to exclude the therapist’s contribution to the relationship. Totalistic approaches, so named by Kernberg (1965), viewed CT as an amalgam of subjective and objective reactions to the client, arising from both the client’s influence and the therapist’s needs, feelings, conflicts, etc. While in terms of definition, advocates of the totalist position (e.g., Heimann, 1950; Little, 1951) acknowledged the role of the therapist’s psychology, they spent more time considering how the client could exert powerful influences on the therapist, and how these influences could be understood and harnessed for interpretation. There have been critical reactions to such views, beginning with Reich (1951) and extending into the present (Eagle, 2000). There have also been voices of integration, such as that of Jacobs (1991), who openly discussed his countertherapeutic reactions and their combined interpersonal and intrapsychic origins. Jacobs noted that his clinical training in the 1970s largely shunned mention of CT, and his didactic training on CT management was confined almost exclusively to works by Reich (1951, 1960). Thus the tensions between exploration and avoidance of CT, and between
interpersonal and intrapsychic explanations, exist in psychoanalytic training settings as well as theoretical debates.

Although research cannot be expected to settle these controversies, based as they are on epistemological proclivities (Coburn, 1999), it has supported the general idea that CT happens, and that both therapist and client contribute to it. Analogue studies have dominated the research on CT management to this point, in an effort to unmask CT influences through controlled environments. Counselors in training, when exposed to client simulations whose personalities, known traits, or material are likely to evoke anxiety, do tend to choose responses that focus attention away from their own role in the relationship (Yulis & Kiesler, 1968); trainees who endorse awareness of CT-related feelings are less likely to engage in this type of avoidance (Peabody & Gelso, 1982). Self-reported belief in the importance of CT is also related to empathic ability as measured by client volunteers, although empathy is not a clear moderator of avoidant interpretations (Hayes & Gelso, 1991; Peabody & Gelso, 1982). Thus openness to looking at one’s self is related to the ability to make another person feel understood. This statement is not far off Freud’s (1910) original recommendation that the therapist “should begin his [sic] practice with a self-analysis and should extend and deepen this constantly while making observations on his [sic] patients” (p. 19). The limitations of self-analysis have been explored by Rosenbloom (1998), raising the question of whether openness to CT-related feelings is adequate for CT management beyond counseling analogues.

Self-reported use of theoretical framework contributed an additive effect to CT management, though not in the absence of an endorsement of CT awareness (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). Thus research confirmed what theory suspected (Coburn,
attitudes toward CT have a more powerful influence on CT management than conceptual ability, which can be subverted to the defensive ends of the therapist.

The fact that analogue studies could capture such relationships suggests that they are indeed powerful; in fact, one question raised by such research is whether the management of CT reactions in real therapy relationships can be influenced by the same traits examined in laboratory studies. Another question raised is how therapist traits, attitudes, skills or knowledge contribute to CT management. Is Freud’s self-analysis enough? If so, how is it extended and deepened?

The first question, on whether analogue findings apply in the field, has begun to be addressed through field studies (Gelso, Latts, Gomez, & Fassinger, 2001; Hayes, Riker, & Ingram, 1997; Rosenberger & Hayes, 2002) using a rationally developed instrument, the Countertransference Factors Inventory (CFI; Hayes, Gelso, VanWagoner, & Diemer, 1991). The CFI includes five proposed CT-management related therapist traits. Results have been mixed, and Latts’ (1996) dissertation revealed flaws in the factor structure of the CFI, even using more carefully selected items. Certain subscales do seem more robust in their relationship to CT management as measured by either CT manifestations or therapy outcomes, particularly Self-Integration, which is meant to capture the overall psychological health and boundary strength of the therapist. Each of the remaining subscales – Self-Insight, Empathy, Conceptual Ability, and Anxiety Management, has also demonstrated some expected relationship, though research design allows for other interpretations.

The second question, how CT is managed, has not been investigated directly. This is perhaps the most clinically relevant question. A therapist who learns that self-integration may be related to CT management, short of opting for further personal therapy, is unlikely to know what
to do with this knowledge. The therapist could then turn to theory, especially the thorough work of Racker (1957, 1968) and theoretical descendants like Hahn (2000), and obtain some pragmatic pointers and raised conceptual awareness. However, said therapist, if imbued with a proper level of epistemological skepticism, may question the network of assumptions upon which such clinical advice rests. An alternative to the existing contributions lies in being both systematic and experience-near in studying the process of CT management. Being systematic implies accounting for assumptions and biases, searching for counter-examples, and exposing any inferences to multiple viewpoints. Being experience-near implies seeking out narrative accounts of CT management or recording them as they occur. Both of these requirements are met, I will argue, in the present study, which asks the following question:

*What theory can usefully explain how a set of experienced psychotherapists manage their countertransference in ways they deem successful?*
Chapter II

REVIEW OF THEORETICAL AND EMPIRICAL LITERATURE ON COUNTERTRANSFERENCE MANAGEMENT

Introduction

Countertransference (CT) has achieved increased prominence in psychoanalytic literature over the years since Freud (1910/1959) introduced the concept. Beginning efforts have also been made to empirically investigate CT and its management. These efforts are essential to advancing knowledge of psychotherapy process as a whole; if the role of CT is not considered, then models of how therapy works or fails to work will have limited applicability to real therapy relationships. This point is borne out by field studies both quantitative (Cutler, 1958) and qualitative (Hayes et al., 1998).

According to a number of theorists (e.g., Cohen, 1952; Racker, 1957; Wolstein, 1959), few if any therapists can completely avoid reactions during therapy that are incompatible with clients’ growth and symptom resolution. Hayes et al. (1998), in their qualitative study of CT, found that a small sample of experienced therapists unanimously reported CT reactions in a majority of sessions with clients. In advancing current understanding of what constitutes effective psychotherapy, then, it seems important to focus on how therapists can manage personal reactions that impede clients’ progress, and even use these reactions to further that progress.

Despite an abundance of theoretical work on CT, from Freud’s earliest conceptualization (1910/1959) through the 1960s (see Orr, 1954, and Singer & Luborsky, 1977, for reviews), empirical study of CT has been sparse, and of CT management even less abundant (Gelso &
Hayes, 1998). The first comprehensive model of CT grounded in empirical evidence has been advanced (Gelso & Hayes, 1998; Hayes, 1995), but a model of CT management grounded in research remains unarticulated. Researchers have proposed several therapist traits involved in CT management and explored their relationships to each other and to CT primarily through analogue designs. Field research on CT management is in an embryonic stage, with only three published studies conducted to date (Gelso, Latts, Gomez, and Fassinger, 2001; Hayes, Riker, & Ingram, 1997; Rosenberger & Hayes, 2002).

The possible reasons that CT should be such a neglected topic of research bear upon the motivation for the present study. First it must be said that historically, psychodynamic theorists and clinicians have not been research-oriented. The case study has been the chief mode of investigating therapy process, and problems here of theoretical self-affirmation and external validity have been thoroughly vetted by critics such as Spence (1994). In the last decade, psychodynamic therapy has undergone both quantitative and more rigorous qualitative exploration, (e.g., Hayes et al., 1998; Hill, Carter, & O’Farrell, 1983). These developments hold out promise for further attention to CT within psychotherapy research.

There is another potential explanation for the lack of empirical attention to CT until recently, also reflected in the uneven history of theoretical attention to the topic (Racker, 1957): collective resistance to self-awareness on the part of research-practitioners. The image of the effective psychoanalyst set forth by Freud of being able to thoroughly rid one’s self of CT reactions through personal or self-analysis, may have effectively discouraged admissions of human frailty (Racker, 1957). Again, recent developments hold promise. The increasing prominence of intersubjective views in psychoanalytic theory helps to legitimize the
interpersonal needs that therapists bring to the therapy relationship, without minimizing the importance of managing those needs.

Another barrier to research noted by many researchers is the difficulty of operationalizing constructs like CT. Not only is there controversy over what to include in the range of the CT construct, but there is the question of how to capture a process that is, at least until the therapist attempts to confront it, typically outside of awareness. Even if one is able to capture CT as it surfaces in the therapist’s awareness, the therapist may be motivated to distort this awareness in order to be socially acceptable or defend against painful emotions like shame and anxiety (Hahn, 2000). Furthermore, CT is complex in that it is both intrapersonal and interpersonal: clients react to CT and to the therapist’s attempts to manage it, and these reactions in turn may affect the therapist. Lastly, there is the matter of teasing CT out from other variables, such as transference in the client, and gaps in clinical expertise in the therapist.

These speculations on the dearth of research on CT lead up to the motivation for the present study. It is my contention that only under conditions that minimize the risks that accompany self-awareness can therapists openly describe their CT reactions and attempts to cope with them. Furthermore, only through such contextually embedded description can processes be captured that are truly informative to practicing clinicians. Even if theoretical advancement were the sole aim of such inquiry, advancement depends, I will argue, on first-person accounts of CT management experiences. Each of these points will be taken up in turn.

Various attempts have been made to indirectly assess CT on the assumption that therapists will, by definition, not be fully aware of or willing to disclose their CT reactions (e.g., Cutler, 1958; Rosenberger & Hayes, 2002). However, there are several counterarguments to this assertion. First, therapists have privileged access to their subjective experiences. While these
experiences may be subject to self-serving bias, they are still unique in their richness and clinical relevance.

Second, therapists have an ethical obligation to serve their clients that depends on their willingness to be truthful with themselves. This obligation, which in the management of CT ideally serves to offset defensive motivations, may be harnessed in the research interview by encouraging reflexivity. In this way some of the bias to which self-reports are subject can be minimized.

Third, self-awareness is forever incomplete and in process. The CT reactions that enter therapists’ awareness are precisely those about which they can do something useful. To know through indirect means that a therapist has a pattern of interpersonal behavior that remains stubbornly outside of the therapist’s awareness is to learn nothing about CT management, unless one is going to follow the therapist longitudinally through a course of personal therapy or supervision.

Provided that methodological rigor and the creation of an atmosphere of safety in the research process allow a minimally biased picture of CT management to emerge, qualitative study of CT management processes can provide invaluable links among theory, practice, and research. Qualitative research can apply a more rigorous method to deriving theory from practice than psychodynamic case studies have utilized, thus supporting or bringing into question existing assumptions. Qualitative research can then generate hypotheses that are grounded in both theory and practice; these hypotheses can be followed up using more positivist approaches. Finally, qualitative research can inform practice by alerting the practitioner to potential problems and solutions. The generalizability of qualitative research rests in the reader, who can use the results not as answers directly applicable to cases, but as heuristic devices for exploring practical and
theoretical questions. The following review of theoretical and empirical literature will provide an additional context supporting the relevance and timeliness of a qualitative approach to investigating CT management.

Review of Countertransference Management Theory

A few words on terminology are needed at the outset. Terms vary for the two people involved in a professional relationship aimed at improving the psychosocial functioning of (at least) one of the two. I have chosen to use therapist, client, and therapy throughout this review, as being the most generic terms with the fewest associations with a particular theory or type of professional training. That said, most of the theoretical work on CT comes from the psychoanalytic community, and therefore direct quotes introduce the terms (psycho)analysis, (psycho)analyst, and patient or analysand. A number of empirical studies have been conducted by researchers within the field of counseling psychology, introducing the terms counselor and counseling. The applicability of theory embedded in psychoanalytic language and practice to more generic forms of therapy will be addressed, but otherwise the terms from different traditions should be considered equivalent.

The review of literature leading up to the current research questions will unfold in the following way. First, the evolution of the concept of CT in psychoanalytic theory will be traced up to the present day. This historical overview will include the role of CT in the therapeutic relationship, and the implications of differing conceptions of this role for the management and use of CT. Central concepts in psychoanalytic theory will be defined and explored in terms of their relationships with CT management, including unconscious communication, projective identification, the therapist’s narcissistic vulnerability, therapist and client object relations,
empathy, and intersubjectivity. Next, CT management research will be reviewed and compared and contrasted with theoretical contributions. Methodological limitations in the research will be considered as they affect interpretation of the results and the relevance of the present study. Finally, models of CT management from theoretical and empirical perspectives will be outlined, leading to a series of unresolved questions regarding CT and its management.

Overview of Theoretical Contributions

The development of ideas about CT and its management within psychoanalytic theory and research may be seen as a dialectical conversation about the role of the therapist’s subjectivity within the therapy relationship. Subjectivity is a term encompassing the therapist’s experience and the ways that experience is thematically structured in response to personal history and the present situation (Stolorow & Atwood, 1992). Both therapist and client project their subjectivity into the relationship between them, constituting an intersubjective field, i.e., a dynamic interplay of subjectivities that carries its own momentum (Stolorow & Atwood, 1992). The two subjectivities are therefore both self-regulating and mutually regulating. It is through these regulation processes that CT is thought to play itself out for good or for ill (Bacal & Thomson, 1996; Coburn, 1998).

Writers of different time periods and theoretical inclinations have attributed different amounts of power and importance to each participant’s subjectivity and to the intersubjective field itself. These differences reflect important and interrelated developments within psychoanalytic theory, such as object relations, self-psychology, and constructivism or postmodernism. These differences have also had important technical implications for the use and management of CT, and each perspective has had blind spots that other perspectives have
illuminated. If one integrates these perspectives, the result is a theoretically robust view of the role of CT in the therapy relationship.

However, research lags far behind theory and therefore we must bear in mind that theory has only the weight of its own arguments to support it. The anecdotal case study typical of psychoanalytic writing is helpful in bringing theory to life but does not represent a confirmation of theory, given that many theoretical views can be applied to a single event, such as a therapy relationship. Spence (1994) argues that psychoanalysis has relied on rhetoric in the absence of research. While some may see rhetoric in a positive light, as appropriate to a hermeneutical approach that recognizes the inevitably constructivism of investigations of our own nature, Spence sees dangers in rhetoric as a means of disguising logical fallacies and tacit assumptions in the compelling garb of metaphor. He observes that Freud himself saw metaphor as a temporary means of capturing intuitions that must be clarified through clinical observation; instead, psychoanalytic metaphors such as the unconscious have become reified to the extent that clinical observations can no longer be uncoupled from them. This is one reason that a discovery-oriented approach is taken in the present study. The challenge in conducting a review of largely psychoanalytic theory is to use it to generate productive dialogue (with both research participants and research team members) without limiting that dialogue to the confirmation of pre-existing, psychoanalytically informed ideas.

In exploring the dialogue among psychoanalytic thinkers about CT and its management, it is also important to note that thinkers of other persuasions are poorly represented if at all. Only one contribution was found outside the psychodynamic literature (Rudd & Joiner, 1997). We do not know how theory related to CT management would have evolved within an existential-humanistic, cognitive-behavioral, or multicultural tradition. On the other hand, we do know that
CT is a phenomenon ubiquitous in psychotherapy of all theoretical persuasions; to be personally unaffected by a client would itself be a form of CT.

Several terms unique to psychoanalytic or psychodynamic thinking should be defined at the outset in order to avoid conceptual confusion. First are the interlocking ideas of self representation, object representation, and object relations. Horner (1998) sees object representations as mental schemata of others developed in the context of early relationships with primary caretakers. Self representations also develop in this context, in response to how the caretakers reflect the emerging sensory, affective, and cognitive experiences of the child, as well as through the introjection of aspects of the primary caretaker with which the child comes to identify. Some such introjects may be taken on because they are disowned by the caretaker(s), projected onto the child, and responded to relationally as if they had existed in the child from the beginning.

Object relations refer “to the inner mental structures of the self and object representations and their dynamic interplay, along with associated characteristic feelings, wishes, and fears” (p. xiii). Horner (1998) views the concept of the object as important in that it allows us to distinguish a person’s mental representations of others from the people themselves. Furthermore, object relations go from relational processes experienced by the developing child to psychic structures that organize further relational experience. In therapy, this organization of relational experience plays itself out in the transference and countertransference.

One area of contention in psychoanalytic thought has been the extent to which the client’s versus the therapist’s object relations are enacted in CT. The chief mechanisms through which the client’s object relations can be played out by the therapist’s inner experience and outer behavior is thought by some to be projective identification. First proposed by Klein (1946),
projective identification is “an attempt by the client to rid the self of an unwanted part by fantasizing that it is instead part of the object (e.g., the therapist) and then pressuring the object to behave in a manner congruent with the projection” (Schultz & Glickauf-Hughes, 1995). This is the parallel in therapy to the process of projection and introjection described above in the context of the child-caretaker relationship. Although terms like object relations, introjection, projection, and projective identification are useful as shorthand for complex intrapsychic-interpersonal processes, their association with psychoanalysis (and the impossibility of directly observing them in action) makes it difficult to see the processes they designate as operating outside the narrow context of psychoanalytic relationships. Even if such processes occur in all therapies, they are merely one metaphorical approach to understanding the dynamics of CT and its management.

One pantheoretical conceptualization of the therapy relationship that can help to organize this review and ground it in a broader context than psychoanalysis is the tri-partite model advanced by Gelso and Carter (1985, 1994). This model consists of three interrelated and overlapping components: the working alliance, the transference-countertransference relationship, and the real relationship. These components are claimed to exist in all therapy relationships, regardless of the theoretical orientation of the therapist. The first component, the working alliance, has been extensively studied and found to bear a strong relationship to therapy outcome (Horvath & Greenberg, 1994). The role of the working alliance in therapeutic process and outcome was first discussed extensively within psychoanalysis by Greenson (1965), and was applied more generally to psychotherapy by Bordin (1979). Bordin proposed that the working alliance consists of three aspects: an agreement as to therapy goals, an agreement as to the tasks needed to reach these goals, and a positive emotional bond between therapist and client.
The second component of the therapy relationship outlined by Gelso and Carter (1985, 1994) is the transference-countertransference relationship. This component is characterized by repetition, potentially by both partners, of past relationship dynamics in the therapy relationship. This component is viewed as both a potential source of interference in the therapeutic work, and as a possible focus of such work. In psychodynamic or interpersonally oriented psychotherapy, the examination and correction of past relationship patterns as they manifest within the therapy relationship is considered essential. Greenson (1965) believed that the working alliance provided the support the client needed to withstand the intense emotions and interpersonal conflict that can arise when working directly with transference.

The third and final component suggested by Gelso and Carter (1985, 1994) is the real relationship. This is the most elusive construct to define, but it can be understood in contrast to the transference-countertransference relationship as the realistic reactions of the client and therapist to each other, based on accurate mutual appraisals rather than projections of past significant relationships. The real relationship may overlap with the positive emotional bond aspect of the working alliance, to the extent that this bond is not a result of positive transference (such as idealization of the therapist as an omnipotent parent). Gelso and Carter also thought of the real relationship as an outcome of transference resolution, as the client comes to see the therapist as a person rather than a receptacle for projected aspects of internal object relations.

The Classical View of CT and Early Dissent

The classical definition of CT espoused by Freud (1910/1959) held that CT was the therapist’s response to the client based in the therapist’s own unresolved conflict: “We have begun to consider the ‘counter-transference’, which arises in the physician as a result of the
patient’s influence on his [sic] unconscious feelings, and have nearly come to the point of
requiring the physician to recognize and overcome this counter-transference in himself…. [W]e
have noticed that every analyst’s achievement is limited by what his own complexes and
resistances permit, and consequently we require that he should begin his practice with a self-
analysis and should extend and deepen this constantly while making his observations on his
patients” (p. 19, in Wolstein, 1988).

Thus Freud approached CT chiefly as a menace to therapy. The therapist should be alert
for any deviations from therapeutic neutrality, any manifestations of unresolved conflicts, and
engage in self-analysis or further personal analysis. The danger of CT lay in its unconscious
acting out, which would disturb the development of the client’s transference by injecting the
therapist’s own wishes and fears into the relationship. This intrusion would interfere by reducing
the therapist’s ability to act as a blank screen facilitating transference development. The
transference, or acting out of the client’s conflicts within the therapeutic relationship, was
deemed essential to the success of therapy because such conflicts could only be examined and
resolved in vivo, not at a distance. In sum, CT reactions were to be managed before they
manifested in countertherapeutic action.

Freud’s perspective can be understood in the context of the model proposed by Gelso and
Carter (1985; 1994). First, if CT intrudes too heavily into the transference component of the
relationship, the transference will be contaminated and be impossible to analyze as the product of
the client’s conflicts. CT can also be understood in terms of the working alliance. If CT
manifests as punitive or avoidant attitudes or actions toward the client, it can interfere with the
development of the positive emotional bond within the working alliance. If, on the other hand,
CT manifests as overinvolvement with the client to meet the therapist’s interpersonal needs, then
the tasks and goals of therapy may be diverted from the client’s growth, also subverting the working alliance.

The influence of CT on the real relationship is more difficult to define in Freud’s terms. It would seem that CT, as a manifestation of the therapist’s personal side in the therapy relationship, could contribute to the client’s accurate perceptions. On the other hand, CT as the therapist’s distorted perceptions of the client or therapy relationship could interfere in the real relationship on both sides, because the therapist’s distortions could become shared by the client. As will be seen, it remained for later theoreticians, who placed the real relationship in a more central position, to examine how CT and this component of therapy interact.

Early dissent to the Freudian position on CT came from Ferenczi (1920) and some of his students (Balint & Balint, 1939; DeForest, 1942). Ferenczi, a friend and former analysand of Freud who belonged to the inner circle of Freud’s disciples, gradually broke with Freud on the possibility of therapeutic detachment and neutrality. He viewed CT as being pervasive and intuitively known to patients, and advocated sometimes rather extensive disclosure and exploration of CT within the therapy relationship, to the point of experimenting with mutual analysis. For these heretical developments he was excommunicated from the psychoanalytic mainstream, but according to Jacobs (1999), Ferenczi’s insights can now be considered forerunners of current intersubjective theory, reviewed below. One may speculate that Freud’s emphasis on therapist neutrality represented a form of institutionalized CT, based on Freud’s fears of being engulfed in the client’s dynamics at a time when scientific objectivity was emphasized. The fact that revisions of psychoanalytic theory have all been in the direction of greater use of one’s subjectivity during a time of deconstruction of the ideal of objectivity argues for this speculation.
Balint and Balint (1939) added the observation that transference and CT interact in complex ways, mutually influencing each other's development. They argue that it is impossible for the therapist to avoid disclosing personal traits through nonverbal behavior, office décor, and other subtle manifestations. On the other hand, Balint and Balint saw the transference as largely developing undisturbed by CT as defined in this broad sense, as long as “the individual variety of technique shall procure sufficient emotional outlet for the analyst” (pp.228-229). This reference to the therapist’s needs anticipates the intersubjectivist view of CT management to be reviewed below.

DeForest (1942), in reviewing Ferenczi’s technical innovations, argued that the therapist must be receptive to the client’s reactions to CT: “It is probable that the analyst’s sincere evaluation of his [sic] own personality and a willingness to learn from his patient of his own short-comings, changing them when possible, are among the most essential elements in the development of the patient’s growing reality sense, his [sic] tolerance, and his capacity to bear disappointment” (p. 134). Thus these early critics of the classical technical approach to CT brought the real relationship component of therapy into the foreground.

The Totalistic Vision of CT

The first thorough reconsideration of CT departing from Freud and those who expanded on his perspective began with papers by members of the British object relations school, Winnicott (1949), Heimann (1950), Little (1951), Cohen (1952) and Racker (1953, 1957). These theoreticians advocated an expansion of the concept of CT to include reactions other than those rooted in the therapist’s own conflicts, based on the idea that some CT reactions are realistic ones based primarily on the client’s influence on the therapist. Kernberg (1965) named this
conception of CT totalistic and contrasted it with the classical view. This broadening of scope was supported by two arguments. First, therapists’ reactions that might be useful to understanding the client were no longer excluded from consideration by seeing personal reactions to clients as necessarily distorted (Heimann, 1950). Second, the exclusive focus on reactions that were deemed harmful vestiges of incomplete analysis might lead therapists to avoid self-awareness, whereas a totalistic view encouraged a more self-accepting stance (Cohen, 1952; Racker, 1957). Little (1951) identified several types of CT within the totalistic view: the therapist’s unconscious attitude toward the client; the therapist’s equivalent of transference; ways in which the therapist needs the client’s transference (and presumably works against its resolution); and conscious attitudes and behavior toward the client. Little’s categorization of CT served to underscore the variety of therapist reactions that might be informative or destructive depending on the therapist’s degree of awareness.

Within the broad scope of the totalistic definition of CT, Winnicott (1949) made an important distinction. Subjective CT was synonymous with the classical definition, whereas objective CT was the reaction induced by the client, one that anyone would find it hard not to experience in the presence of the client. Objective CT, although not named as such, was implied in Freud’s (1912/1957) discussion of the therapist using the unconscious as an instrument for understanding the client’s unconscious. Objective CT is also equivalent to the role responsiveness discussed by Sandler (1976), or the interpersonal pull discussed by Sullivan (1953) and other interpersonal theoreticians (Kiesler, 1973; Strupp & Binder, 1984).

Cohen (1952) asserted that even the most apparently objective CT reactions are colored by the therapist’s character. She advocated a totalistic definition of CT as a starting point, going on to discuss the importance of winnowing out subjective from objective reactions. Cohen saw
anxiety in the therapist as the hallmark of both types of CT, and argued that anxiety should act as an impetus to self-awareness. Later writers did not follow up on this idea, in spite of its theoretical and practical import. Empirical investigations of CT management brought anxiety back under consideration, as will be reviewed below.

Racker (1953) argued that even CT reactions that are highly subjective contain information about the client, because they are partially based on identifications with psychic structures in the client. Racker (1957) confronted the myth of the therapy relationship as occurring between a sick person and a healthy one. He attributed to this myth a rigid denial of CT masquerading as objectivity. Racker suggested that true objectivity was a middle ground between denial of and drowning in CT reactions, whereby the therapist maintained an internal division between the self experiencing CT and the self observing and analyzing CT reactions.

Racker (1957) went on to distinguished between two types of CT identifications, concordant and complimentary, that held important information about clients. Concordant identification was essentially synonymous with empathy, a resonance between an aspect of the self and that same aspect in the client. Development of concordant CT could be inhibited by therapists’ alienation from aspects of themselves that resonated with aspects of clients’ selves. Complimentary identification was the therapist’s identification with the client’s internalized objects, often with countertherapeutic consequences. Racker (1957) gave the example of a therapist becoming identified with a client’s punitive superego. This process occurred through projective identification, in which the client elicited complementary responses that confirmed the projection of the unwanted object. Unable to tolerate the perceived punishment by the therapist, the client might then become angry, treat the therapist punitively, and lead the therapist to identify with the client’s guilty ego. The therapist could only become free of these identifications
and reversals by observing them; through interpreting the dynamics to the client, the client could also make a breach in the vicious cycle of transference and CT. To the extent that therapists have not been able to separate from and observe in themselves their own object relations, they are more likely to get lost in the vicious cycle. This is how Racker (1957) saw subjective and objective CT interacting.

While Heimann (1950) asserted that CT should never be disclosed to clients, being a burden to them, theoreticians within the totalistic camp disagreed about whether and when to disclose subjective CT reactions. Some believed that clients were often already aware, though perhaps not able to verbalize, therapists’ acting out of subjective CT (Little, 1951). Thus disclosing CT reactions could have several benefits: improving clients’ reality-testing (DeForest, 1942), modeling the ability to integrate disowned realities (Berman, 1949) and strengthening the real relationship (Winnicott, 1949).

The totalistic view of CT can be understood as straddling the transference-countertransference and real relationships within the tri-partite model of the therapy relationship (Gelso & Carter, 1985, 1994). The totalistic view comprises both the therapist’s neurotic reactions to the client (those originating in unmet needs or unresolved conflicts) and those that are expectable reactions to the client, what Sandler (1976) termed “role responsiveness.” Subjective CT belongs clearly to the domain of the transference-countertransference relationship, and corresponds in kind to the client’s transference as classically defined. Objective CT, on the other hand, is the therapist’s objective reaction to the client’s transference. It is the transitional nature of objective CT that allows it to have potential therapeutic value, in helping the client to understand transference reactions and relinquish them in favor of the real relationship. On the other hand, the subjective component of otherwise objective CT may provide the emotional
impetus for the therapist to pay attention to what is occurring in the therapy relationship, if such emotion is not defensively avoided.

The therapeutic use of objective CT can also be understood in relation to the working alliance. First, the strength of the working alliance, particularly the positive emotional bond, may determine the extent to which the client can accept the therapist’s interpretation of transference-countertransference phenomena. The working alliance is in turn influenced by the ability of the therapist to separate subjective from objective CT, keep the subjective CT from being acted out too destructively with the client, and use objective CT reactions in a manner well-tuned to the client’s capacities and the developing therapy relationship. As will be described in more detail when considering intersubjective views of CT management, the therapist’s willingness to consider and sometimes explore with the client how objective and subjective CT intertwine may be crucial for the working alliance.

This description of how objective CT and its management play out in the three components of the therapy relationship can be contrasted with the classical view, which has been elaborated by Reich (1951, 1960). Reich argued against CT as a means of understanding the client and conveying empathy. She described empathy as a process of trial identification, by which the therapist attunes to the client’s subjective experience. She added that in order for empathy to result in therapeutic behavior, the therapist must disengage from the trial identification and return to a stance of neutrality in order to interpret the client’s experience. She identified two ways in which this process can fall short of being therapeutic, each determined by subjective CT manifestations. The trial identification could fail to occur at all, based on the therapist’s aversion to the client, which may be triggered by disowned aspects of the therapist’s self. On the other hand, if the therapist becomes overidentified with the client and cannot
disengage from the trial identification, neutrality and accurate interpretation become impossible. Reich believed that the totalistic definition of CT obscured the extent to which personal reactions may be obstacles to empathy, thus leading therapists to run the risk of turning a blind eye to incompletely analyzed aspects of their character, and failing to remove the distorting influence of these blind spots. Although Reich appeared to disagree with Racker (1957) in distinguishing empathy from concordant CT, there is much overlap in their recommendations for managing CT so that objective responses predominate.

Modern Reconsideration of CT Management

Much of the literature on CT in the last two decades has focused on the mechanism of projective identification. Contemporary theoreticians such as Coburn (1998) and Eagle (2000) have clarified the dangers in seeing CT as primarily an objective reaction to projective identification. They note that in assuming that they can act as an unbiased receptacle for projective identifications, therapists may ignore the influence of their own subjectivity on the process. Eagle also points out that the idea that the therapist identifies with the client’s projected objects is unnecessary to understand the therapist’s reactions; instead, a combination of the therapist’s role responsiveness (Sandler, 1976) and own unresolved needs and vulnerabilities better explains responses to the client.

Similar to Reich (1960), Eagle (2000) considers the contemporary view of CT as a tool for knowing the client as indistinguishable from empathy. This assertion raises the question of the usefulness of a category of objective CT. However, there may be two ways in which objective CT is a clinically and theoretically useful distinction. First, experiencing an expectable, non-neurotic reaction to a client is not the same as empathizing with the client. An objective CT
reaction of this kind may lead to empathy if the therapist is able to mentally disengage from the reaction long enough to wonder what it signifies about the client. Another way in which the objective CT category is useful is that often, therapists may need to work on winnowing their subjective from their objective reactions. If one subsumes all emotionally colored reactions to clients under the heading of subjective or classical CT, one risks losing vital information about the client’s conflicts and object relations. If one assumes that all reactions are objective, one risks unconsciously introducing one’s own needs into the therapy relationship and one’s understanding of it.

In contrast to Freud’s ideal of the therapist as a blank screen, or its reincarnation as unbiased receptacle of projective identification, contemporary thinkers on CT have recognized that therapists, as well as clients, communicate about the therapy relationship and about their subjectivity in unconscious ways that are received, consciously or unconsciously, by each other. Coburn (1998) sees unconscious communication as the principle means by which the therapy relationship evolves and is regulated moment by moment. The central implication for CT and its management is that one often has to look beyond the conscious intentions and obvious behaviors of therapist and client to discover how the transference-countertransference relationship is playing out. The key to unlocking these dynamics, argues Coburn, is the therapist’s awareness of mutual narcissistic wounding that may occur as each partner in the therapy relationship attempts to self-regulate in response to the other. As an example, Coburn described how a defensive withdrawal from perceived punishment may be viewed as punishing in itself, leading to a reciprocal withdrawal or more aggressive punishment.

Bacal and Thomson (1996) made a further contribution by defining CT as the outcome of the frustration of the therapist’s object relational needs in the therapy relationship. It is not only
the therapist’s general narcissistic vulnerability that is at stake, but the particular constellation of unmet object needs that the therapist brings to the therapy relationship. Bacal and Thomson asserted that it is the normative process, not a pathological variant, for therapists to expect certain object needs to be met by the client and the therapy relationship; in fact, such needs are built into therapists’ professional personae. The frustration of these needs “will affect the analyst’s capacity to attune and to respond optimally to the patient. If analysts insist on retaining the term ‘countertransference’ (which they will probably do), we believe that it should refer to these reactive or disjunctive phenomena that affect the analyst’s therapeutic function” (pp. 21-22). Thus while affirming the importance of examining subjective CT, Bacal and Thomson defined subjective CT as a normative experience that lies in the intersubjective field, and therefore may yield information about the client. The goal is not so much to separate therapist and client contributions to CT as to connect them within a narrative that describes how each person affects the other.

While acknowledging the potential diversity of therapist needs, Bacal and Thomson (1996) speculated that perhaps “the therapist’s predominant need is for affirmation of his [sic] ability to understand and, in many instances, for his [sic] caring, humanistic motivation” (p. 23). Bacal and Thomson traced a potentially vicious cycle of increased client disruption and decreasingly empathetic therapist reactions, not unlike the cycle described by Racker (1957), but in the language of frustrated needs rather than unrecognized identifications. They pointed out, however, that the therapist can escape or avoid such a cycle through acceptance of the normality of bringing object needs to the therapy relationship. They also traced the gradual development of therapist self-awareness and self-integration that may buffer the therapy relationship against
mutual wounding. Brothers and Lewinberg (1999) called this development and its corresponding process in the client “bilateral healing.”

Schultz and Glickauf-Hughes (1995) articulated a bilateral model of projective identification that included the therapist’s subjectivity. They examined the role of projective identification in treating pathological narcissism, highlighting the interference of the therapist’s unresolved narcissistic needs when these are stirred by the client’s use of the therapist as an extension of the client’s self, whether as mirror of the owned good part or receptacle for the disowned bad part. Hahn (2000) extended this view of CT in considering the role of shame in projective identification and the CT reactions described by Racker (1957). Hahn viewed shame as a primary emotion in that it signals a basic fear, that of severed relations with important objects who help one maintain a sense of being good enough. Much anxiety that the therapist feels would therefore be traceable to shame or anticipated shame. Using Racker’s (1957) distinction between concordant and complementary CT responses, Hahn traced how therapists may identify with shamed or shaming introjects of the client, depending on which the client attempts to project. The therapist who avoids experiencing shame in self or client is then likely to respond by withdrawing from the client, avoiding exploration of the client’s shame-related issues, taking care of the client in an invalidating manner, attacking the self, or attacking the client.

Hahn (2000) asserted that therapists with unresolved shame are more likely to encounter difficulties in clients with similar issues. Hahn advocated for two components in managing shame-related CT: “conceptual understanding of the dynamics involved, and, more importantly, willingness to affectively experience the material that has been externalized…. The goal is to develop a collaborative endeavor in which the devalued and devaluing introjects become
consciously available for discussion, rather than unconsciously acted out by both parties” (p. 19). Hahn adds that self-disclosure of the therapist’s identification and avoidance may be helpful to clear the way for collaborative discussion.

Hahn’s recommendations for managing CT are akin to Reich’s (1960). Reich proposed that therapists must engage in a two-step process in order to manage subjective CT (the only kind she recognized as CT). First, they must become aware of the feelings in themselves that have been elicited in the therapy relationship. Second, therapists must utilize a theoretical framework to make sense of these feelings and analyze their origins, thereby removing their influence on perceptions of and behavior toward clients. This model of CT management is attractive in that it integrates affective and rational knowing, thus having its parallel in therapy itself. Here, rationality is positioned as the way out of emotional entanglements, in keeping with the emphasis in classical analysis on interpretation as cure. In contrast, postmodern and intersubjective thinkers have located therapists’ theorizing within their subjectivity, rather than according it a privileged position.

Coburn (1999) identified the theoretical biases toward embeddedness or transcendence as underlying CT and its management. The attitude of embeddedness is defined by Coburn as assuming “the inevitability and inextricability of one’s subjective state” (p. 107), whereas the attitude of transcendence “allows one to feel that one can know and assume something about the patient – something that is presumed to be real and true – via temporarily shedding one’s idiosyncratic, subjective perspective” (p. 110, author’s italics). This distinction is comparable to the differing attitudes toward projective identification outlined above, recognition of the role of one’s subjectivity vs. belief that the client has deposited an aspect of self into the therapist.
Coburn (1999) took the additional step of connecting these attitudes to epistemological biases, to positivism and post-positivism. Coburn does not reject transcendence, but sees it in a dialectical relationship to embeddedness. A therapist in order to be effective may need to shift between knowing and not knowing, between communicating to the client an air of certainty, and demonstrating openness to collaborative learning. Coburn thought of CT as arising when the therapist becomes convinced of some truth about the client and is unable to acknowledge how this truth is embedded in subjectivity, even in the therapist’s defensive reaction to the client’s behavior. Often, the “truth” about the client is an artifact of the transference-countertransference relationship, in that the client, in responding negatively to the therapist’s certainty and resulting misattunement, manifests the very behavior about which the therapist is convinced. The real relationship and working alliance would therefore be threatened by the therapist’s lack of self-awareness. Coburn’s contribution is to ground this lack of self-awareness in a bias toward transcendence. In the case material presented by Coburn, therapist and patient ultimately “loosened and unraveled their intersubjective dysjunction through a gradual, thorough investigation of their discrepant, subjective perspectives and concomitant experiences of each other” (p. 116). This description echoes the technical stance of Ferenczi (1920) described above.

Bouchard, Normandin, and Séguin (1995) provide a detailed map, grounded in case examples from the psychoanalytic literature, of the process within the therapist of working through CT reactions with subjective and objective components. Although they do not emphasize the exploration of intersubjective space with the client, their understanding of different attitudes with which the therapist may approach CT is closer to the level of experience than most theorists go. The objective-rational attitude is facilitative of impartial tracking of dynamics in client and self, and the detachment involved is in the service of understanding rather
than defense. The reactive mode is parallel to the classical view of enactment of CT. The 
reflective mode is viewed by Bouchard et al. as a parallel to Freud’s concept of freely hovering 
attention, and the resonance of the therapist’s unconscious with that of the client (Freud, 
1912/1957). It is in this mode that the therapist may participate in the relationship more fully 
while not getting lost in enactments of CT. Bouchard et al. note that the reflective mode is 
arduous and difficult to maintain. They divide it into phases of emergence (of unconscious 
material), immersion (an adaptive regression into the material for the sake of understanding and 
resolution), elaboration (meaning making of the experience for both participants) and 
interpretation. These stages are an in-depth and more intersubjective expression of Reich’s 
(1960) concepts of affective-cognitive CT management and empathic identification with the 
client.

To return to the tripartite model of the therapy relationship (Gelso & Carter, 1985, 1994), 
classical, totalistic, and intersubjectivist views of CT management can be seen as placing the 
transference-CT relationship and real relationship in different positions with each other, with 
unique consequences for the working alliance. The classical perspective sees the real relationship 
as an outcome of transference resolution, which in turn depends on keeping CT out of the 
therapy relationship. The working alliance is therefore largely dependent on positive transference 
for the emotional bond, and for the therapist’s authority and expertise for the agreement as to 
goals and tasks (Greenson, 1965).

The totalistic view includes CT, at least objective CT, within the real relationship, as an 
accurate perception of the client. At times this perception includes transference, when the client’s 
patterns of interaction trigger CT reactions. The working alliance may be enhanced by the
therapist’s willingness to self-disclose, or at least by the therapist’s ability to separate subjective from objective CT and make accurate interpretations.

Finally, the intersubjective stance relocates the transference-CT relationship within the real relationship. The needs of both therapist and client are seen as interacting in the present, and CT is viewed as originating in the therapist’s difficulty accepting personal needs into awareness. In both participants the needs may be transferred from past relationships but they are also real needs in the present. CT management is the recognition and possible discussion of how the therapist’s human needs (e.g., for interpersonal connection and a self-efficacy) get frustrated in the therapy relationship. The working alliance is built upon the therapist’s willingness to be human without sacrificing the primary goal and task of helping the client to grow through the real relationship.

To summarize the evolution of theory on CT and its management, classical emphasis on the dangers of subjective CT was answered by a totalistic redefinition of CT, and focus on the potential therapeutic uses of objective CT. A synthesis of these dialectically opposed positions has been articulated by psychoanalytic thinkers affiliated with self psychology and in particular with the concept of intersubjectivity. These writers have described how subjective and objective CT play out between therapist and client, originating in the selfobject needs of both participants. Ideas on CT management have also evolved, from Freud’s recommendation to keep CT out of the therapy room, to self-disclosure, to a focus on the client’s contribution, to a focus on the relationship between therapist and client as the field in which needs are frustrated, articulated, and met. Underlying most of these technical approaches lies Freud’s original recommendation to constantly extend and deepen one’s self-analysis. However, the attitude with which one approaches such analysis has ranged widely with the degree to which the human reactions of the
therapist are seen as suspect or potentially constructive. Furthermore, Rosenbloom (1998) observes the tendency of psychoanalytic writers to sound suspiciously efficient in their self-analysis when recounting tales of CT management. Self-analysis can certainly serve defensive ends, and Rosenbloom adds that CT data are often partial and take time to evolve.

A distinctive approach to CT management founded in cognitive language and concepts is that of Rudd and Joiner (1997), who view therapy transactions in light of a Therapy Belief System (TBS) that includes the interpersonal schemata and expectations of therapy of both therapist and client. Rudd and Joiner offer a method of charting such beliefs according to pre-existing categories. The client may consciously or unconsciously see self as victim, collaborator, or caretaker in the therapy relationship, and may see the therapist as victimizer, collaborator, or savior. The therapist in turn may see self as victim, collaborator, or savior, and correspondingly view the client as an aggressor, collaborator, or helpless victim in need of saving. These beliefs are associated with affective and behavioral manifestations as well as automatic thoughts. Conflicts and collusions may exist in the perspectives of client and therapist, and Rudd and Joiner suggest that clear cognitive treatment plans can be formulated by exposing these interplays and the core interpersonal schemata that activate them. In addition, deviations from the ideal of a collaborative relationship can be understood and dealt with before treatment is derailed.

Although Rudd and Joiner describe their model of CT management as true to cognitive theory and caution against importing psychodynamic concepts into cognitive therapy, it seems clear that interpersonal schemata are object relations in other language. The difference of approach may lie less in understanding CT-transference dynamics than in how the therapist deals with them in therapy. The focus of change is the beliefs as opposed to the relationship itself, as
with intersubjective approaches. However, a further contribution made by this cognitive interpretation is that it demonstrates that CT and psychodynamic language do not have to be wedded to each other. The signifier is not the signified. The picture that emerges from the above review of theory is one of two people who in their very effort to engage in a therapeutic relationship, end up mobilizing anxiety, shame, and defensive reactions that threaten to lock the relationship into patterns that are not growth-enhancing. Opposing these regressive forces is the joint dedication of the therapist and the client to developing a relationship that is healing, primarily for the client, but also for the therapist. One might see the real relationship as a destination and the working alliance as a vessel to reach that destination, while transference and CT are the headwinds that must be understood and harnessed (perhaps through tacking maneuvers) in order for the working alliance to be an effective vessel. It is the winds that provide the energy for movement, anxiety-driven though it may be.

Limitations of Psychoanalytic Theory

Another precedent set by Freud and his adherents was more related to the process of understanding CT. The anecdotal case study, set forth by Freud as a scientific means of testing hypotheses, was established as the principle mode of research into CT and its management. There are a number of problems with the uncontrolled case study as a scientific instrument. First, many psychoanalytic ideas are inferentially distant from the observable behaviors of analyst and analysand. These behaviors could support a variety of psychological and meta-psychological theories. In fact, as Kuhn (1962) points out, theories are neither verifiable nor falsifiable; they merely fall by the wayside when other theories supplant them as being more useful. Second, even those ideas that seem testable in the laboratory of the consulting room are impossible to
falsify. If a therapist predicts that an interpretation will be met with resistance, but is accepted, then was the interpretation false? An hypothesis more closely related to CT management would be, if the therapist becomes distant whenever the client manifests a childlike dependence, then the therapist must be identified with the client’s dismissive father. But what if the therapist is in reality identifying with his own father, or is in fact taking a conscious therapeutic stance? Each of these examples demonstrates that metapsychological assumptions, such as the existence of unconscious internalized relationships and the relative freedom of the therapist from such unconscious influences, find their way into the apparently tight logic of psychoanalytic thinking.

Freud was quite capable of making assumptions explicit, then building a whole edifice of theory as if they were true. The problem that psychoanalytic thinking has inherited from Freud is the tendency to forget the metaphorical nature of the underlying assumptions. The “as if” quality of such thinking has re-emerged in constructivist approaches to psychoanalysis, which emphasize the utility rather than veracity of explanations. However, there is still the question of whether such explanations remain useful or generative outside of psychoanalysis. Before reviewing research on CT management, which investigates more generic forms of therapy, it is important to apply this question to psychoanalytic explanations of CT and its management.

This question really has two parts. Does CT develop or manifest in a sufficiently similar manner across theoretical approaches to warrant the same inferences? For example, does psychoanalysis possess qualitatively or quantitatively distinct dynamics, such as regression, projective identification, or transference, that must be taken into account when understanding CT? Whether or not such differences exist, the second aspect of this question is whether CT management is a distinctive process in psychoanalysis.
Given major changes in psychoanalytic thought and practice that have placed the experience of the relationship on a par with insight as a curative factor, there may be fewer differences between psychoanalysis and more broadly psychodynamic approaches than in the past. A more salient distinction may lie between time-limited and long-term forms of psychodynamic psychotherapy, in which the client may develop a greater dependency on and trust in the therapist, and therefore more powerfully transfer patterns of relationship and related needs onto the therapy, including those related to trust and dependency.

The CT responses of the therapist could then be distinctive also. In terms of complementary CT responses, the therapist may experience pulls toward parental behaviors and feelings that evoke conflict related to nurturing and punishment, attachment and separation, being a good object/bad object. In terms of concordant CT responses, the therapist may identify with the unmet dependency and individuation needs and good self/bad self splits that the client experiences. These dynamics may require the therapist to exercise a deeper self-analysis and manage more primitive anxieties than in briefer forms of therapy. The point is that in considering the applicability of theory, one should stay open to the possibility that there is no unified process of CT or CT management across therapeutic modalities.

Returning to the question of whether psychoanalytic theory about CT can be applied to other forms of therapy, one may ask what is the parallel in psychoanalytic theory to the failure to reject the null hypothesis in positivist research? Won’t individual theoretician-clinicians always find what they are looking for, whether they are looking in the same or in diametrically opposite directions to their predecessors? A counter-argument is that any one thesis may be self-corroborating, but the dialectical conversation within the field should take care of this. Such dialogue is akin to Consensual Qualitative Research, in that different research team members
expose each other’s biases and are forced to ground their conclusions in observation. On the other hand, psychoanalysis, for all its internal divisions, tends to be a rather closed community that may not think to critique many of its shared biases. With this weakness acknowledged, the strength of theory-building methodology seems closely related to a clinical strength of psychoanalysis and its offshoots: interest in the complexity of the therapy experience.

An Intersubjective Model of CT and CT Management

Figure 1 (p. 36) presents a synthesis of theoretical development to the present. Such a synthesis reflects the increasing influence of object relations thought on psychodynamic thinking as a whole. The model incorporates the presumption that the self grows out of a relational context that, when it does not provide good enough empathic attunement, causes the compromises to the integrity of the self that bring most people into therapy. A corollary of this presumption is that a therapy relationship will both provide a context in which empathic failures are re-enacted, and a context in which they can be understood and replaced with good enough empathic attunement. Intersubjectivity holds that both participants in the therapy relationship have experienced empathic failures and consequent insults to the integrity of the self, thus both participants approach the therapy relationship with more or less unconscious relational needs. CT management is therefore the discovery and management of the needs of the therapist and their interplay with those of the client.
Figure 1: An Intersubjective Model of Countertransference and CT Management

Therapist’s experience of empathic failures -> Therapist’s needs and vulnerabilities

Therapist’s needs and vulnerabilities -> Therapist’s shame

Therapist’s shame -> Frustration of therapist’s needs/arousal of vulnerabilities

Frustration of therapist’s needs/arousal of vulnerabilities -> Therapist’s anxiety

Therapist’s anxiety -> Relationship repair and client insight, resumption of client development

Relationship repair and client insight, resumption of client development -> Therapist’s reattunement to client

Therapist’s reattunement to client -> Therapist’s understanding of relations within and between therapist and client

Therapist’s understanding of relations within and between therapist and client -> Therapist’s openness to own needs and vulnerabilities

Therapist’s openness to own needs and vulnerabilities -> Therapist’s self-analysis, therapy, or consultation

Therapist’s self-analysis, therapy, or consultation -> Therapist’s experience of successful attunements

Therapist’s experience of successful attunements -> Therapist’s commitment and theoretical knowledge

Client’s experience of empathic failures -> Client’s needs and vulnerabilities

Client’s needs and vulnerabilities -> Client’s shame

Client’s shame -> Frustration of client’s needs/arousal of vulnerabilities

Frustration of client’s needs/arousal of vulnerabilities -> Client’s anxiety

Client’s anxiety -> Therapist’s interpretation of relationship to client

Therapist’s interpretation of relationship to client -> Therapist’s understanding of relations within and between therapist and client

Therapist’s understanding of relations within and between therapist and client -> Therapist’s openness to own needs and vulnerabilities
Empirical Investigation of CT Management

Empirical investigations have attempted to clarify what therapists traits and skills allow for effective management of CT. Five analogue studies and three field studies on CT management are included in this review; see Gelso and Hayes (1998) for a broader review of research on both CT and its management. All but two of the studies were published in peer-reviewed journals; these were found in a search of PsychInfo using the parameter “countertransference management OR countertransference behavior” (the latter phrase identified studies exploring CT management as a reduction in CT behavior) and excluding theoretical articles. The unpublished studies were known to the investigator.

Just as the tri-partite model of the therapy relationship was of heuristic value in clarifying and integrating theoretical contributions on CT and its management, a theory of CT developed by Hayes (1995) is of heuristic value in examining the empirical contributions. Hayes viewed the entire process of CT and its management as composed of five components: CT origins, triggers, manifestations, effects, and management. Hayes asserted that CT originates in the therapist’s unresolved issues and is triggered by the client’s behavior, speech content, or other therapy events. CT then manifests itself as therapist reactions (cognitive, affective, and/or behavioral) that affect subsequent therapy processes and outcomes either positively or negatively. CT management is defined as therapist traits or behaviors that allow the therapist to minimize or make use of CT manifestations. Hayes’ theory does not invoke highly inferential constructs such as projective identification or selfobject needs, as do psychoanalytic theories, and is therefore an appropriate framework to apply to research.
Research on Individual CT Management Factors

The three earliest studies (Hayes & Gelso, 1991; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987) used or adapted an analogue procedure devised by Yulis and Kiesler (1968) to trigger and measure behavioral CT manifestations in counselor trainees. These studies explored how potential CT management traits of empathic ability, openness toward CT-related feelings, and use of theoretical framework related to the behavioral CT manifestations. A replication of Robbins and Jolkovski (1987) using more sophisticated CT trigger procedures and measures of CT manifestations was conducted by Latts and Gelso (1995).

CT manifestations were operationalized in the first three studies as therapist behavior, namely, the avoidance of personal involvement in counselors’ interpretations. Yulis and Kiesler (1968) had participants listen to 15-minute audiotapes of three actresses portraying clients, one seductive, one hostile, and one dependent. At ten points in each audiotape, participants chose from two scripted responses differing in degree of personal involvement. For example, if both possible responses reflect a client’s anger but one didn’t specify the therapist as the object of that anger, choice of the latter response was considered avoidance of personal involvement.

Peabody and Gelso (1982) examined relationships among three variables in 22 male counselor trainees: empathic ability, openness to affective CT manifestations (hereafter, CT feelings), and behavioral CT manifestations (hereafter, CT behavior). Reasoning that empathic counselors would be receptive to their own internal reactions and less likely to act them out, the investigators hypothesized that empathic ability would be negatively related to CT behavior and positively related to self-reported openness to CT feelings. Thus therapists who rated higher on perceived empathy were predicted to be more likely to include themselves as objects of client reactions when making interpretations.
Peabody and Gelso (1982) used the Empathic Understanding subscale of the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962) to assess the counselor trainees’ empathic ability. Female undergraduate volunteers were randomly assigned to the counselor trainees, with whom they discussed real personal problems for one hour, then completed the BLRI.

To measure self-reported openness to CT feelings, Peabody and Gelso (1982) developed a nine-item survey. Three items regarding the perceived usefulness, frequency across clients, and place of occurrence (inside vs. outside of sessions) of CT feelings, found in subsequent analysis to be highly correlated, were combined to form a single measure of openness to CT feelings. After completing the CT Survey, counselor trainees participated in the analogue designed by Yulis and Kiesler (1968).

Peabody and Gelso (1982) found limited support for their hypotheses. Empathic ability was negatively correlated with CT behavior with the seductive client, but not with the hostile or dependent clients. The authors surmised that the seductive client generated the most anxiety in the counselor trainees, requiring empathic ability to counteract CT behavior. Openness to CT-related feelings was positively related to empathic ability with all three clients. Openness to CT-related feelings was unrelated to CT behavior, although a nonsignificant negative correlation was observed.

In contrast, a fourth item from the CT survey not included in the composite measure, percentage of sessions in which participants saw CT feelings as occurring in their work, was unrelated to openness to CT feelings, negatively related to empathic ability, and positively related to CT behavior. This result suggests that the frequency of CT-related feelings (vs. an attitude of openness to CT) could be detrimental to therapy. This result also implies that more
empathetic counselors may experience fewer conscious CT-related feelings. If supported through further study, this finding would appear to support a more classical view of CT management as the successful eradication of CT, rather than the contemporary view that CT is inevitable and pervasive, even essential to empathy.

Although Peabody and Gelso (1982) did not obtain results strongly supporting a relationship between possible CT management traits and reduction of possible CT manifestations, the problems may lie in the measures and design rather than the hypotheses. The measure of openness to CT-related feelings, being a newly constructed self-report measure of overall attitudes, did not necessarily tap the process, during the counseling analogue itself, of accepting and becoming aware of CT-related feelings that might have facilitated self-involving interpretations. The fact that this measure was related to empathic ability does support the idea that it measures something, and suggests that empathetic counselors may be more accepting of their own emotions as well as those of their clients. Acceptance of emotions may very well bear an important relationship to CT management, but may not be predictive of the specific measure of CT management used here.

Robbins and Jolkovski (1987) used the Yulis and Kiesler (1968) procedure to test a model of CT management based on Reich’s (1960) assertion that in order to manage CT, therapists must first become aware of CT feelings, then understand these feelings by applying a theoretical framework to them. Thus Robbins and Jolkovski hypothesized that openness to CT feelings and use of theoretical framework would interact to reduce CT behavior more powerfully than either ability alone. Openness alone would be insufficient to guard against avoidant interpretations, presumably because without a theoretical framework to make sense of one’s affective reactions, they would remain threatening. The presence of a strong theoretical
framework in the absence of openness to CT-related feelings would not be sufficient for the recognition and reduction of CT behavior.

The 58 doctoral students in psychology who participated first completed measures of use of theoretical framework and openness to CT-related feelings. The first measure, devised for the study by Robbins and Jolkovski (1987), was a three-item Likert scale measuring to what extent counselor trainees’ theories of counseling were articulated, stable over time, and referred to consciously within sessions. The second measure consisted of five items from the CT Survey developed by Peabody and Gelso (1982) regarding the perceived usefulness, appropriateness, and predominant place of occurrence (inside versus outside of sessions) of CT feelings. Having completed these measures, the participants responded to the seductive and dependent client portrayals from Yulis and Kiesler (1968); the hostile portrayal was judged to be less than convincing.

Robbins and Jolkovski (1987) found support for their principal hypothesis. Trainees reporting high levels of theoretical framework manifested less CT behavior (i.e., fewer self-excluding interpretations) only when openness to CT-related feelings was medium or high. When openness was low, high levels of theoretical framework coincided with the most CT behavior. A negative relationship was found between openness to CT-related feelings and CT behavior, validating a nonsignificant trend in Peabody and Gelso (1982); theoretical framework by itself was unrelated to CT behavior.

These results are quite intriguing in that they reflect the ambiguous role of theoretical orientation explored by postmodern psychoanalytic thinkers such as Coburn (1999). In other words, theory may serve both defensive and facilitative functions, depending on therapists’ levels of openness to their subjectivity. Reich (1960) saw the outcome of successful CT
management as empathic attunement to the client, with both affective and cognitive components. Unfortunately, the construct of empathic ability was not included in this study.

A caution should be sounded regarding the interpretation of these first two studies of CT management. Given the lack of any measure of CT origins, these studies could be understood as testing hypotheses unrelated to CT. Choice of the less self-involving interpretation could be based on factors other than CT, such as theoretical orientation, and therefore choice of the more self-involving interpretation could be unrelated to CT management. As traits, empathic ability, openness to CT-related feelings, and use of theoretical framework are related to broader therapeutic factors than CT management.

It was therefore important to establish a connection between the therapist’s subjective state and the behavior that was interpreted as a manifestation of CT. As discussed above, Cohen (1952), in reviewing the preceding theoretical literature, invoked anxiety as the distinguishing hallmark of CT. One test of whether the Yulis and Kiesler research paradigm is really tapping CT is to discover whether therapist anxiety levels are related to the failure to choose more personally involving interpretations.

Seeking to explain CT and its management in terms of anxiety, empathy, and their interaction, Hayes and Gelso (1991) offered two hypotheses: that counselor state anxiety would be positively related to CT behavior, and that counselor empathy would moderate the effects of anxiety upon counselor behavior. Hayes and Gelso theorized that empathic ability could directly override anxiety by shifting counselors’ self-concern to concern for the client. Thus Hayes and Gelso sought the mechanism by which empathy operated to minimize therapist avoidance (Peabody & Gelso, 1982), which theoretically should spring from anxiety.
The 35 counselor trainees who participated first completed the trait anxiety portion of the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970), a twenty-item Likert scale chosen for its established reliability and validity. Trainees then met for 30 minutes each with two volunteer clients instructed to discuss actual personal problems. Immediately after the sessions the volunteer clients completed the Empathic Understanding subscale from the Barrett-Lennard Relationship Inventory. The BLRI was chosen for its high reliability and its previous use in CT research (Peabody & Gelso, 1982). Two clients were used for each trainee to obtain more accurate ratings of trainees’ empathic ability.

One week after meeting with volunteer clients, trainees chose among the scripted responses to the seductive and dependent client portrayals (Yulis & Kiesler, 1968). After responding to each audiotape, the trainees completed the state anxiety portion of the STAI.

Hayes and Gelso (1991) did not find the expected positive relationship between state anxiety and CT behavior when results for both genders were analyzed together, but did for male trainees. To explain this difference the authors applied previous research demonstrating that men tend to withdraw from relationships when anxious. The hypothesis that empathy would moderate the relationship between state anxiety and CT behavior was not supported. The small sample of male trainees prevented the authors from conducting hierarchical regressions with respect to gender. It is also possible that the research design obscured an existing relationship, in that empathic ability was measured in a separate counseling analogue from state anxiety and CT behavior.

Latts and Gelso (1995) examined the utility of the two-step model of CT management explored by Robbins and Jolkovski (1987) for counselors responding to survivors of date rape. The first hypothesis was that counselor openness to CT-related feelings would be inversely
related to CT behavior. The second hypothesis was that openness would interact with use of theoretical framework, such that low openness combined with high theory would lead to more CT behavior than high openness combined with high theory. The authors also expected that male counselors would display significantly more CT behavior than female counselors would in response to female victims of date rape. The underlying idea was therefore that counselors would experience anxiety (CT manifestation) related to the CT trigger of date rape, and would most easily tolerate this anxiety and continue to facilitate client expression if CT were managed by allowing feelings into awareness and placing them in a theoretical context.

Prior to the counseling analogue, the 47 counselor trainees recruited by Latts and Gelso (1995) completed a survey of therapeutic factors including measures of openness to CT-related feelings and theoretical framework identical to those used by Robbins and Jolkovski (1987). Latts and Gelso improved the analogue design over previous ones in two respects. Videotapes, rather than audiotapes, were used to more closely resemble the reality of counseling; two actresses were used to minimize effects based on individual characteristics. The measure of CT behavior was also changed to allow for spontaneous rather than scripted responses. Based on categories developed by Bandura, Lipsher, and Miller (1960) and refined by Hayes and Gelso (1993), Latts and Gelso trained independent raters to code participants’ responses to the videotapes, resulting in rations of avoidance to approach responses.

Latts and Gelso (1995) found no significant relationship between openness to CT-related feelings and CT behavior, but the interaction of awareness of feelings and theoretical framework did predict CT behavior (avoidance responses in comparison to approach responses). High levels of theoretical framework combined with low levels of openness to CT-related feelings predicted the highest level of CT behavior, and high levels of both predicted the lowest level. Thus Latts
and Gelso added support to the Robbins and Jolkovski (1987) model by using a different CT behavior measure and finding the same interactive effect between awareness of CT feelings and theoretical framework. However, in contrast to Robbins and Jolkovski, Latts and Gelso did not find that openness to CT-related feelings alone reduced CT behavior; the authors speculated that the stimulus of a date rape survivor was too anxiety-provoking in the absence of a theoretical framework.

Taken together, the four studies just reviewed (Hayes & Gelso, 1991; Latts & Gelso, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987) suggest that client and therapist characteristics do interact to influence the extent to which therapists make facilitative responses, at least under analogue conditions. In no case did the research up to this point examine CT origins; instead, the choice of client analogues was designed to provoke expectable discomfort in therapists. The addition of measures of CT might have strengthened the case that CT was being investigated – in particular, subjective CT rather than the average, expectable reaction characteristic of objective CT. The narrow and contrived operationalization of CT manifestations used in the Yulis and Kiesler analogue procedure also limits the external validity of the first three studies. Even the Bandura et al. (1960) method of measuring CT manifestations is somewhat narrow, excluding overinvolvement and perhaps confounding it with approach responses.

A final point is that potential CT management traits were chosen on a theoretical basis but without any effort to be comprehensive. Therefore traits more central to CT management could have been ignored in favor of empathic ability, openness to CT, or use of theoretical framework. The studies that follow attempted to correct for this potential oversight.
Research Based on the Countertransference Factors Inventory

The development of an inventory of CT management factors (CFI; Hayes, Gelso, VanWagoner, & Diemer, 1991) allowed researchers to broaden the scope of therapist traits and skills examined in relation to CT management. The CFI is a rationally derived scale of 50 items grouped into five subscales: Self-insight, Self-integration, Anxiety Management, Empathy, and Conceptual Skills. The Empathy subscale includes both cognitive and affective aspects of empathy, consistent with Reich (1960). Conceptual Skills and Self-Insight are also closely aligned with Reich’s (1960) formulation of CT management, as well as the broad psychoanalytic consensus about the importance of awareness of CT origins and manifestations in managing and, according to some writers, utilizing subjective CT. Anxiety Management speaks to the central role of anxiety in CT first proposed by Cohen (1952). Anxiety can be a signal that CT is occurring, an affective CT manifestation as well as a trigger for defensive CT behavior. Self-Integration is the intriguing newcomer to the family of potential therapist traits predictive of effective CT management. It is possible that Freud (1910/1957) had such a construct in mind when he emphasized the importance of self-analysis for the analyst, asserting that the analyst could only carry an analysis as far as his own had gone. Self-integration is also implied in the model of CT management as bilateral healing advanced by Brothers and Lewinburg (1999).

Self-Integration items appear to fall into two clusters (Latts, 1996): those that speak to the sense of wholeness and balance in the therapist’s personality, and those that speak to the therapist’s ability to maintain healthy boundaries with the client and differentiate personal experience from that of the client. This latter aspect of self-integration is synonymous with the ability to distinguish between subjective and objective CT.
Hayes et al. (1991) examined the content validity of the CFI by asking experts on CT to rate the relative importance of each item to CT management. On a Likert scale (1=not important to 5=very important) the mean ratings of the five subscales were as follows: Self-insight, 4.3; Self-integration, 4.3; Anxiety Management, 3.7; Empathy, 3.6; and Conceptual Skills, 3.4. The CFI lacks extensive psychometric research but possesses high internal consistency (Hayes et al., 1991; Hayes, Riker, & Ingram, 1997) and discriminant validity in terms of distinguishing reputedly excellent from average therapists (Van Wagoner, Gelso, Hayes, & Diemer, 1991).

Gelso, Fassinger, Gomez, and Latts (1995) were the first to use the CFI to test some of the theoretical relationships between potential CT management traits and CT manifestations. Using videotaped female client portrayals varying only in sexual orientation, the investigators studied the roles of homophobia, therapist gender, and CT management traits in the CT manifestations of 68 counselor trainees. Participants’ ability to manage CT was predicted to be negatively related to CT manifestations with both lesbian and heterosexual client actresses, and to moderate the effects of homophobia on CT manifestations. In this design the counselor’s homophobia represented the CT origin, while the client’s homosexual orientation was the intended CT trigger.

Reflecting their belief that unitary measures of CT may be too simplistic, Gelso et al. (1995) used three measures of CT manifestations: cognitive, behavioral, and affective. The cognitive measure (following Hayes & Gelso, 1993) was the number by which the counselors over- or underestimated how many sexual words were used by the client actresses. The behavioral measure was a ratio of avoidance responses to the sum of avoidance and approach responses, following a similar method and coding system to that used by Latts and Gelso (1995). The affective measure was state anxiety (State-Trait Anxiety Inventory; Spielberger et al., 1970).
Participants’ CT management ability was measured through their former supervisors’ ratings on a modified version of the Countertransference Factors Inventory (CFI; Hayes, Gelso, VanWagoner, & Diemer, 1991).

No significant relationships were detected from one-tailed tests of correlation between the CFI and any measure of CT manifestations when client sexual orientation conditions were examined together. Gelso et al. (1995) noted that overall homophobia levels were low in participants compared to normative scores (Daly, 1990), making relationships between homophobia and CT management factors more difficult to detect. However, the Anxiety Management and Self-Integration subscales of the CFI were negatively related to state anxiety in the lesbian client condition. These CT management traits may have buffered counselor trainees from homophobic responses. An exploratory measure of CT, overinvolvement (a single-item, 5-point Likert scale) did not demonstrate any relationship with CT management, perhaps because the expected CT origin of homophobia was more conducive to avoidant reactions.

Although the use of homophobia as a measure of CT origins appears to come closer than previous studies to establishing links among CT origins, triggers, and manifestations, it is questionable whether homophobia is a manifestation of an individual conflict/need requiring management. The lack of relationship to the Self-Insight, Empathic Ability, or Conceptual Ability subscales implies that reductions in state anxiety related to homophobia may not depend on the same strategies required for issues rooted in personality or object relations. Homophobia can be understood in both cultural and psychological ways, but participants in this study would be unlikely to process their anxiety in elaborate ways in a brief counseling analogue. In fact, direct management of anxiety and the resilience provided by overall psychological health would
be logical means of coping with homophobia-related anxiety in this situation. Applications to understanding CT management remain obscure.

Through a field study of CT management and therapy outcome, Hayes, Riker, and Ingram (1997) sought greater external validity and clinical relevance than analogue research could claim. They sought to test hypothesized negative relationships between CT management ability and CT behavior, and between CT behavior and positive treatment impact. In terms of the Hayes (1995) theory of CT, positive treatment impact would be inversely related to CT effects.

Hayes et al. (1997) used a revision of the Countertransference Factors Inventory (CFI-R) to measure CT management ability. Of the 50 original items, 26 with acceptable content validity (Hayes et al., 1991) were included. All items from the Conceptual Skills subscale were omitted because only one had adequate content validity. Counselors’ former supervisors completed the CFI-R with respect to the counselors, who completed a self-report version.

Hayes et al. (1997) used two measures of CT manifestations, both behavioral. A single, 5-point Likert item (the “CT Index”) was developed by the authors to assess counselors’ and current supervisors’ level of agreement with the statement that the counselor’s behavior in session was influenced by areas of unresolved conflict. Current supervisors also counted avoidance, approach, and other counselor responses via live observation of sessions, using the same categories developed by Bandura et al. (1960). Treatment impact was measured with client, counselor, and supervisor forms of the Counseling Services Assessment Blank (CSAB; Hurst, Weigel, Thatcher, & Nyman, 1969). The CSAB was chosen for its validity, reliability and appropriateness to a college counseling setting.

Counselors completed the CFI-R prior to seeing clients. Treatment duration ranged from 4 to 20 sessions (M = 8). Counselors and their current supervisors completed the CT Index
immediately after sessions and immediately after supervision. Two weeks after termination, counselors, supervisors and clients completed the CSAB.

Hayes et al. (1997) found that counselor trainees’ self-report scores on the CFI-R subscales were unrelated to their former supervisors’ ratings of the counselor trainees on the CFI-R, and to CT manifestations. However, former supervisors’ ratings of counselors’ CT management ability on the Empathy and Self-integration subscales of the CFI-R were inversely related to the CT manifestation of counselor avoidance/approach ratios. The other subscales, Anxiety Management and Self-Insight, were unrelated to either measure of CT manifestations.

When Hayes et al. (1997) analyzed all cases together, significant relationships failed to appear between either measure of CT manifestations and the four measures of treatment impact (counselor, supervisor, client, and combined CSAB scores). However, the authors found that in the cases defined as less successful based on a cut-off score chosen prior to data analysis, both measures of CT manifestations bore a strong negative relationship to combined CSAB scores. Degree of CT manifestation was roughly equivalent in more and less successful cases.

Hayes et al. (1997) interpreted these results as suggesting that in more successful cases, therapeutic factors such as a strong working alliance may prevent CT manifestations from negatively affecting therapy, while in less successful cases, the presence of CT manifestations is related to negative outcomes. This interpretation suggests that, at least in brief treatment, CT manifestations are not so necessary to avoid as to counterbalance. It could be expected that in longer-term treatment, CT manifestations could become more ingrained and problematic, requiring resolution rather than compensating factors. However, CT resolution may also be more easily achieved in longer-term treatment.
Successful and unsuccessful cases were not distinguishable on the basis of degree of CT manifestations; only within the unsuccessful cases did a relationship exist between CT manifestations and outcome. Therefore treatment success in Hayes et al. (1997) cannot be attributed to the negative relationship of empathic ability and self-integration to CT manifestations. A design linking all three facets of CT (manifestations, effects, and management) might have clarified the impact of CT management skills on therapy outcome.

Gelso, Latts, Gomez, and Fassinger (2001) studied the relationship between counseling outcome as rated by counselor-trainees (n = 32) and their supervisors (n = 15) and supervisors’ ratings of the trainees on the CFI-R. Therapy was limited to 12 sessions or less and supervisors listened to audiotapes of all sessions. This study differed from the research conducted by Hayes et al. (1997) in that it removed the intermediary variable of CT behavior. Thus a more direct relationship between CT management and outcome could be evaluated. Outcome was measured using the Counseling Outcome Measure (Gelso & Johnson, 1983), a therapist-report four-item instrument measuring clients’ progress or lack thereof in feelings, behavior, self-understanding, and overall change.

Gelso et al. (2001) found significant positive relationships between the total CFI-R score and both counselors’ and supervisors’ ratings of client improvement. Of the CFI-R subscales, only Anxiety Management and Conceptualizing Skills were positively related to both ratings of client improvement; Self-Integration was also related to the trainees’ ratings of client improvement. Neither Self-Insight nor Empathy was related to outcome.

Gelso et al. (2001) did not speculate about the nonsignificant relationships between some CFI-R subscales and outcome, except to say that the small sample size may have caused some relationships not to emerge. The investigators did infer that therapists, at least trainees, may help
clients change more when the therapists can maintain clear boundaries between their own and clients’ experiences, manage their anxiety effectively, and understand client dynamics within a conceptual framework. However, because CT management traits were not measured in relation to CT origins, triggers, or manifestations, the inference that their positive relationship to outcome reflects a process of CT management is highly speculative.

Noting the fragmentary nature of the empirical literature on CT and CT management, Rosenberger and Hayes (2002) chose a single case design to study in depth the interaction of the five aspects of CT identified by Hayes (1995): CT origins, triggers, manifestations, effects, and management. Rosenberger and Hayes hypothesized that in sessions with higher frequencies of CT triggers (defined in relation to CT origins), CT manifestations would be more prevalent, but this impact would be moderated by one or more CT management factors, as reflected in the therapist’s self-ratings on the CFI-R.

Rosenberger and Hayes (2002) identified CT origins through a pre-treatment interview with the therapist and through ratings on the Need Scales from the Adjective Check List (ACL; Gough & Heilbrun, 1983) provided by the therapist and three of her friends. Discrepancies between the therapist’s self-ratings and ratings by her friends were interpreted as indicative of CT origins, on the assumption that less conscious needs were more conflictual. CT triggers were identified through independent raters’ review of client speaking turns for material consistent with the therapist’s CT origins.

There were two measures of CT manifestations. Avoidance behavior was measured using the method developed by Bandura et al. (1960), using independent, trained raters. The Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 1997) was utilized to capture CT other than avoidance. The ICB measures positive CT (e.g., overidentification with client) and
negative CT (e.g., a punitive or critical stance toward client). This inventory was also completed by independent raters. CT effects were measured by client and therapist ratings, immediately after sessions, of session depth and smoothness (Session Evaluation Questionnaire, Stiles & Snow, 1984); of the therapist’s attractiveness, trustworthiness, and expertness (Counselor Rating Form – Short Version, Corrigan & Schmidt, 1983); and of the working alliance (Working Alliance Inventory, Horvath & Greenberg, 1989). CT management was measured through therapist self-ratings on a revised version of the CFI (Gelso et al., 2001) immediately after sessions.

Rosenberger and Hayes (2002) found a modest positive relationship between the therapist’s self-ratings on the CFI-R and the client’s (but not the therapist’s) ratings of the WAI. Thus in sessions in which the client felt a stronger working alliance was present with the therapist, the therapist tended to rate her own CT management skills more highly. CFI-R self-ratings were strongly and positively related to the therapist’s self-ratings on social influence characteristics of expertness, attractiveness, and trustworthiness; the common source of the ratings does raise the possibility that some other variable in the therapist was responsible for elevations on both inventories. The therapist’s self-ratings on social influence characteristics were in turn negatively related to the presence of CT triggers. However, the presence of CT triggers was, contrary to expectation, negatively related to the CT manifestation of avoidance behavior. Together these two relationships suggest that in the presence of conflictual material, the therapist did not act out countertransference through avoidance, but did feel less confident of possessing qualities of an effective therapist.

These results suggests that this therapist, when confronted with client material related to her own conflicts, sought a stronger bond with her client that was reflected in her own perception
of the working alliance, but may also have favored smoother rather than deeper sessions. CFI-R
ratings were strongly and positively related to both the therapist’s and the client’s ratings of
session depth, but not of session smoothness, suggesting that the use of CT management factors
may have facilitated greater depth of sessions, though not necessarily at times when those factors
were most needed, i.e., in the presence of CT triggers.

Rosenberger and Hayes (2002) interpreted the above results as suggesting that in this
particular therapy dyad, CT was well-managed but tended toward overidentification rather than
avoidance, possibly as a function of therapist gender. They speculated that low intensity of CT
triggers and a strong working alliance may have buffered the effects of CT on therapy. The
relationship between the CFI-R and session depth suggested that the therapist’s ability to manage
CT allowed a deeper exploration of the client’s issues regardless of how conflictual they may
have been for the therapist. The client raised such issues an average of nine times per session,
and the therapist’s speaking turns were rated as avoidant only ten times over the 13 sessions.
Rosenberger and Hayes speculated that another dyad in which CT manifestations were more
abundant and the working alliance was weaker would yield further valuable insight into CT and
its management.

This single-case study of CT and its management revealed that a therapist may react to
the presence of CT triggers in ways other than avoidance, such as overidentification, as predicted
by Reich (1960). In this process some of the therapist’s objectivity, perspective, or ability to
confront the client may be sacrificed. In such cases both client and therapist may experience CT
as pleasurable and fail to notice it. Whether such reactions can in fact lead to negative therapy
outcomes remains to be empirically explored.
The four studies using versions of the CFI to investigate CT management demonstrate that some significant correlations exist, both in analogue situations and in the field, among measures of rationally derived therapist traits, therapy process variables, and therapy outcome. Some of these process variables are measures of the quality of the therapy relationship, some of the presence of CT triggers and manifestations. The theory advanced by Hayes (1995) relating CT origins, triggers, manifestations, effects, and management, is far from receiving confirmation, although the link between CT management and CT manifestations has the most support. Nor are the CT management traits ostensibly captured by the CFI consistently related to components of CT, although self-integration shows some promise. One complication in interpreting this inconsistency is that a single version of the CFI has not been used consistently. Evidence of reliability and validity based on one version cannot be automatically applied to others, so the psychometric strength of the CFI remains suspect.

Summary of Research

Taken as a whole, and leaving aside the measurement and design problems discussed above, the research on CT management suggests that a therapist’s ability to be empathically aware of the subjective experience of both self and client, to accept this experience, and to relate it to a theoretical understanding of therapy, allows the therapist to maintain an optimal level of involvement with the client when faced with client traits or behaviors that are potentially disturbing. This description of CT management overlaps significantly with the intersubjectivist view articulated in recent psychoanalytic theory. The empirical literature goes further in specifying certain traits that predispose the therapist to being empathetic toward self and client.
While all the elements of this description remain somewhat speculative, they are certainly useful to generate further study.

Rationale for the Present Study

At this point there seem to be three alternatives: to carry forward with further investigation and replication using available measures while expanding knowledge of their utility, to develop more sensitive measures of CT management, or to back up and explore CT management in a discovery-oriented way, embedded in the context of actual therapy relationships. These alternatives are not mutually exclusive. However, strong arguments can be made for the priority of discovery over hypothesis-confirmation.

Given the ambiguous nature of the psychotherapy relationship, measurement and design issues are naturally tied to epistemological concerns. Qualitative approaches would be in keeping with what a growing number of researchers see as a paradigm shift in psychotherapy process research (Hill, 1994; Orlinsky & Russell, 1994; Rice & Greenberg, 1984), from hypothesis testing to pattern discovery. Such a shift reflects a tide change in the philosophy of science that occurred several decades ago (Kuhn, 1962; Polanyi, 1962), from positivist views of knowledge acquisition (i.e., human behavior can be described in terms of a set of verifiable, or at the very least not yet falsified, propositions) to a more constructivist view, in which behavior, perception, even scientific theory are seen as socially constructed. Positivism emphasizes a deterministic view of human behavior: we act on the basis of our social conditioning in interaction with our biological imperatives. Thus in theory, if one knew enough about people, one could perfectly predict their behavior. In contrast, the constructivist view places the freedom to create one’s own story at the core of behavior. Qualitative researchers seek to both participate in and capture this
process of constructing, deconstructing, and reconstructing meanings. Therefore such processes can only be captured through further meaning-making, inevitably incorporating the researchers’ perspectives into the research. This increased subjectivity must be made explicit and grounded in dialogue and data, rather than eliminated.

For the above reasons, hypothetico-deductive approaches such as those taken by all of the researchers on CT management to date are limited by their inability to access and describe the free act of meaning-making that, within a constructivist paradigm, is central to the resolution of CT. One might argue that we need to know whether a relationship exists before we invest time in understanding it. But such an argument reifies constructs and gives them priority over understanding intersubjective processes. Instead, qualitative researchers set conceptual boundaries to their investigations while allowing patterns to emerge from the data collected within those boundaries (Strauss & Corbin, 1998). In this way processes like CT management are explored within the relational context in which they operate.

The interpretive activity involved in qualitative research can seem to lack scientific rigor from within the positivist perspective predicated on the elimination of personal, subjective judgment (Madison, 1988). Madison views interpretation as the ground of how we exist in the world, rather than as a specific method to be applied. There is no transcendent perspective from which to judge interpretations that is not in itself interpretive. Instead, Madison sees the criteria for interpretation as normative, or involved in the contemplation of the good and the means to achieving it. Interpretive decisions are similar to ethical ones in that they depend on the researcher’s ability to apply norms that are in keeping with the object of study. In the case of CT management, norms appropriate to the subject would seem to include respect for the experience of the therapist and the client; a thorough effort to question whether interpretations could lead to
harm in practice (an example is the use of the concept of projective identification to avoid awareness of subjective CT); and an acute awareness of the influence of the interpreter’s and participants’ subjectivity in an area of inquiry that may threaten images of the disinterested investigator or the competent therapist. Over time, through its many definitional turns, CT has come to encompass subjectivity and intersubjectivity themselves. A research approach that reflexively takes its own subjectivity into account and acknowledges the social contexts reciprocally interacting with this subjectivity seems wholly fitting to the subject at hand.

The social context can be understood at a number of mutually embedded levels, from the research team to academia to Western civilization, or in another direction, to the familial and cultural contexts in which each researcher on the team developed as a person in the world. One might think of such layered, interactive contexts as introducing a hopeless amount of distortion and ambiguity into the research process. However, missing from such epistemological despair is the very necessity of truth being generated from social contexts. Truth cannot exist outside of the circle of interpretations (Gadamer, 1989). One only has a communal responsibility to the subject matter, which is human experience and interaction, to prevent the theoretical arrogance and divorce from the data of which psychoanalysis has been accused (Spence, 1994). The communal nature of this commitment informed the choice of Consensual Qualitative Research as an initial method in the present study. Ultimately the study evolved into a grounded theory, for reasons described in Chapter III. Grounded Theory also honors the communal responsibility for discovering truth, by including research participants and the reader in the circle of interpretations.

One may question whether a discovery-oriented approach is necessary given the detailed theoretical exploration of CT management present in the psychoanalytic literature; surely this
body of work can already generate a plethora of testable hypotheses. The problem is that such an approach limits the discovery of multiple views of CT management. Confirmation of conceptual relationships posited by psychoanalytic thought, such as a positive relationship between awareness of unmet interpersonal needs that are being further frustrated by the client and ability to modify CT behavior, will generate increased certainty rather than increased knowledge. And this certainty can lead practicing clinicians to shoehorn their experiences with clients into pre-existing beliefs. Therefore the research question asked in the present study is: *What theory can usefully explain how a set of experienced psychotherapists manage their countertransference in ways they deem successful?* It is hoped that the range of experiences and interpretations that the participants offered has yielded a theory both deep and broad.
Chapter III

METHOD

Introduction

Although researchers on psychotherapy have been slow to explore subjects through qualitative methods, there has been some movement in recent years. In 1988, Rennie suggested that grounded theory was an appropriate method of researching psychotherapy. From 1992 to 1998, 15 studies were published (according to PsychInfo search using “grounded theory” and “psychotherapy” as keywords). In the equivalent time period since 1999, the frequency tripled, with 44 studies. In a chapter in a recent volume, Rennie (2002) reviewed a group of grounded theory studies on the client experience of humanistic psychotherapy.

Most studies have been dissertations, indicating that the next generation of researchers on psychotherapy may be gravitating more toward grounded theory and other qualitative methods. As qualitative studies gain in credibility and yield useful clinical wisdom and conceptual richness, it is my hope that these methods will enter into a complementary relationship with the more accepted tradition of hypothesis testing. Qualitative research methods generate meanings and descriptions and are therefore helpful in identifying constructs and relationships that may be central to a useful understanding of the phenomenon in question. Quantitative research methods may then be used to find quantitative measures for these constructs and test relationships to determine whether there is a significant probability that correlational or causal connections indeed exist among the constructs within the population to which one hopes to generalize.
Not only does qualitative research systematize the discovery process that precedes quantitative research, it also generates a level of richness useful in its own right, one that cannot be attained through quantitative methods alone. Therapeutic processes are complex, and the quantitative research tradition in psychology has been criticized for failing to generate applicable knowledge, in that abstract relationships are difficult to contextualize and apply to individual cases (Edelson, 1994).

This chapter provides a rationale for the qualitative methods chosen to explore the research topic, the principles and procedures involved, and an epistemological critique of what the results of such methods mean and do not mean. Qualitative studies are not replicable in the same manner as quantitative studies; the level of detail provided here is meant to convey the degree of trustworthiness of the process rather than allow for exact replication. Some of the steps in data gathering, data analysis, and theory building depend upon the insight yielded from previous steps. However, a reader who wants to engage in a similar exploration of the same or some other aspect of psychotherapy process should find useful information in the following description of method.

From Countertransference to Reactivity

In the data analysis and subsequent discussion I have chosen the term “therapist reactivity” in favor of “countertransference.” These are meant to be equivalent terms, with the new term encompassing the meaning of countertransference intermediate between classical and totalistic definitions (see Chapter II). This meaning includes any reactions to the client that are potentially counter-therapeutic, so long as the therapist observes some personal origin to the reaction. This definition is congruent with the instructions in the interview protocol for
participants to identify personal reactions. Reactivity goes beyond specific reactions to include the whole process of how reactions are generated and played out in the therapy relationship. Therapist reactivity runs the spectrum from highly determined by the therapist’s individuality to highly determined by the client’s individuality.

I have chosen to replace the term “countertransference” for several reasons: the negative stigma attached to countertransference due to its Freudian legacy; its association with a particular theory of psychotherapy; the multiple definitions in research and theory that can create conceptual confusion; and the advantages of the term “reactivity,” described below.

One can compare “reactivity” to the alternative term “personal reaction” (used in the interviews) to make its advantages clear. The word “reaction” implies a one-time event rather than a broader process. A reaction may be viewed as conscious and deliberate, whereas reactivity has a somewhat involuntary connotation. Reactivity also implies both a tendency and the activation of that tendency. This dual meaning reflects the range of therapists’ experiences of reactivity as described in the interviews, and as modeled in the theory.

Grounded Theory with Consensual Qualitative Elements

Although located clearly within the boundaries of the grounded theory tradition, this study was initially undertaken as a Consensual Qualitative Research (CQR) study. CQR shares many assumptions and methodological steps with grounded theory, especially in terms of development of the research question, participant selection, the interview process, and the early stages of data analysis. CQR transitioned into grounded theory at the point that all categories (major steps in the reactivity management process, and other elements of the therapy relationship) had been identified, the interview transcripts had been divided into meaning units
(usually a sentence or clause, occasionally several sentences), and all meaning units had been assigned to categories. Categories, called *domains* in CQR, are broad areas into which fall thoughts conveyed by the participants. Together the categories cover the major themes or process steps that convey the entire phenomenon being described. Three interviews had also been through the next step, developing core ideas. Core ideas are phrases that capture the essence of individual meaning units. Core idea development is not a part of grounded theory, but it was a useful practice in scanning meaning units for their contribution to the theory, whether an additional subcategory (variation within a category), or a process link between categories.

The overall process of data analysis is similar between CQR and grounded theory, with some important differences. The discovery process is generally inductive (from data to theory) rather than deductive (theory predicts data). However, rather than being a linear process, as in hypothesis testing, both grounded theory and CQR require movement back and forth between theory and data, as particular data suggests theory and theory is then tested against the remainder of the data. Implications of already grounded theoretical propositions can also be logically extrapolated and then tested against the data.

Grounded theory differs from CQR in that it is more useful in understanding processes, whereas CQR tends to be more limited to describing themes and variations, but not relationships among steps in a process. CQR is also more concerned with representativeness of particular themes or variations to the sample, implying that the frequency with which a theme occurs indicates its relative significance. Grounded theory treats exceptional data not as less representative of the sample, but as needing to be understood within the overall theory, which may need to change in order to accommodate exceptions. In fact, consideration of how variations can be understood together allows grounded theory to attain a depth of explanation that may be
generative of further understanding of the phenomenon under consideration. Furthermore, by offering a close look at processes grounded theory offers practitioners (in this case, psychotherapists) a road map to identify choices and their potential consequences.

Grounded Theory Defined and Critiqued

Glaser and Strauss (1967, p. 3) originally defined a grounded theory as one which must “fit the situation being researched, and work when put into use.” Although Glaser and Strauss ended up being at odds over how grounded theory should proceed (Dey, 1999), they do seem to have agreed on the desired outcome. Strauss and Corbin (1998, p. 15) further defined a theory as “A set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena.” The understanding sought in the present study does appear to fit fairly well with the above definitions. An integrated framework is sought which has explanatory power, and its power is related both to the degree the framework rises out of participants’ representations of their experiences, and to the breadth and depth of the theory: its ability to explain a wide range of variation, and its use of basic ideas about the nature of people, relationships, and psychological growth.

One of the criteria set forth by Strauss and Corbin, prediction, is perhaps too ambitious a goal, in that the variables involved in a complex human interaction like therapy do not lend themselves to predictions. One would have to know the relative strength and interactions of many variables in each case before making any predictions. Instead, a theory is sought here that has the power to guide rather than predict. The theory presents options for therapists to both respond to their reactivity and understand and adjust for the client’s reactions to this response.
Relationship Between Theory and Reality

In the present version of grounded theory, the individual participant accounts are understood as examples of a more abstract process that has an internal necessity. Internal necessity springs from the nature of the participants as human beings. As a physical parallel, one might ask how we know that human beings have two eyes. A random sample would tell us that almost all human beings have two eyes. However, this is not an explanation springing from internal necessity, and in fact the exceptions seem to disprove the claim that human beings necessarily have two eyes. An explanation arising from internal necessity takes into account the human need for stereoscopic vision in order to successfully navigate a three-dimensional world. All one has to do to justify the statement that “humans have two eyes” is to try to perform normal tasks with one eye closed: they become awkward, consume greater attention, and in some cases involve greater risk.

Grounded theory attempts to discover the overall nature of a social-psychological process: how it happens, what subjective meanings and strategies the participants in the process bring to bear, how preceding and contextual factors influence its paths and outcomes, what effects the outcomes have on the participants and the social context. By focusing on social-psychological situations, grounded theory deals not only in interactions, but in what people tell themselves about themselves and their interactions. One may develop multiple perspectives on what happens without ever determining that one version is privileged over another. In this study I have chosen to take therapists’ word for how they understood their experiences of managing reactivity, including how their clients responded. Although there is always the danger of a transference cure (Freud’s term for client improvement rooted in clients’ interpersonal pattern with the therapist), client improvement does in a broad sense offer an objective grounding to
therapist accounts. Ironically, how well the therapists were able to understand (and therefore represent) their clients’ side of the story was, in the therapists’ view, at least in part a result of their own reactivity management.

Like therapists’ views of themselves or their clients, a grounded theory is continuously revised to account for differences in the data, until the best fit seems to be achieved. As with the saying that poems are never completed, only abandoned, a grounded theory can never be complete in that future revisions are always possible. A grounded theory may also be supplanted by another that achieves greater explanatory power or fits better with the worldview of its time and place.

Kuhn (1962) observed that theories are not replaced because new theories disprove them, but because new theories help us make sense of more previously unexplained realities. Even the concept of internal necessity allows for theory modification: I may decide that seeing is not so much necessary as it is a means to a necessity, that of negotiating the sensory world. My theory is then about the ability to perceive in three dimensions through triangulation, a more inclusive concept than stereoscopic vision.

One may ask whether concepts that seem useful or even unavoidable in explaining participants’ accounts are culturally encapsulated. In another time or place would non-psychological concepts seem much more fitting? Would it seem inevitable that the client’s change from an emotionally distant to an emotionally expressive demeanor be understood as caused by astrological activity, the shifting balance of humors in the body, or angelic and demonic influences? The answer is certainly yes. Readers would also be able to see such explanations as inevitable and use them to guide their interventions. The implication of this cultural encapsulation is that researchers, participants, and readers are all drawing from broad
conceptual agreements. A theory is only inevitable to the degree that people inevitably think within a set of constructs determined by their community. A grounded theory may be thought of as an explanation offered within a community, from one group to a larger group within the community. Furthermore, when (as in this study) research participants also belong to the same field as researchers, the shared conceptual vocabulary of that community delimits both the possibilities for the interaction being explained, and the possibilities of the explanation.

How then do we account for theoretical diversity within a community? To the extent that competing psychological theories within the larger community of psychotherapy research and practice each have their own conceptual frameworks, the conceptual vocabulary may no longer be shared. One might recruit participants with a shared cognitive-behavioral framework instead of a psychodynamic one, and come up with a different theory of reactivity management. Or both factions might turn up in the same sample. To integrate these conceptual frameworks and vocabularies and speak to a wider audience, it might be necessary to identify concepts that have both cognitive-behavioral and psychodynamic equivalents. Alternately one would need to argue that psychotherapists of different theoretical persuasions are actually engaged in different types of activity when managing their reactivity. In reviewing the frameworks implicit or explicit in the twelve therapists’ descriptions of reactivity management, it appears that some key assumptions about human nature were held in common, whose ramifications resulted in all of the concepts and relationships among concepts necessary for theory synthesis. These key assumptions are described in Chapter IV.

According to my reading, Glaser, Strauss, Corbin and Dey all seem to have missed this constructivist critique of grounded theory. Dey (1999) takes the originators of grounded theory to task for making claims about the ability of grounded theory to not only fit the data, but to grow
out of it in some unmediated way free of interpretation. But Dey seems to fall into the trap of seeing interpretation as calling the groundedness of grounded theory into question. In other words, *fit* is not the same as *truth*. I would argue that fit does not mean truth in some absolute sense, it means coherence in relation to experience (rather than coherence in relation to being internally consistent or complete but not necessarily mapping onto experience – the chief critique of psychoanalytic theory). When we go about our daily lives embedded in communities of meaning, all we need is fit. Truth, in fact, is how we name fit when it is described from within a community of meaning.

If a grounded theory is fitting then it also becomes useful. For example, I suspect that Roger’s theory of necessary conditions for humanistic psychotherapy (Rogers, 1951) has passed into wide parlance not only because it was subjected to empirical research, but also because the constructs of unconditional regard, genuineness, and accurate empathy had traction: they mapped well onto therapists’ experiences and guided them toward action. Improving clinical practice is my primary motivation in conducting this study.

Theoretical Sensitivity

Unlike quantitative research, which can be critiqued for conformity to clear, replicable steps of data gathering and analysis, in grounded theory as with other qualitative traditions, much depends upon the commitment and characteristics of the investigator(s). Strauss and Corbin (1998) identify the abilities to step back and critically analyze situations; to recognize the tendency toward bias; to think abstractly; to be flexible and open to helpful criticism; to be sensitive to the words and actions of respondents; and to have a sense of absorption and devotion to the work process. These qualities may be synthesized into a single construct: theoretical
sensitivity. Glaser (1978) authored an entire book on this subject as it applies to grounded theory. Such sensitivity is also remarkably similar to that needed by an able therapist seeking to manage reactivity. Psychological needs (and perhaps physical needs that may have psychological effects, like sleep) would therefore seem to present the same risks for both the grounded theorist and the therapist. In fact, for the investigator tiredness, cherished beliefs that have become part of a professional and personal identity, assumed understanding of the meaning of words used by participants fueled by a desire to come across as professionally mature, and the desire to complete the dissertation and move on in life, all set some limits on the above qualities. The investigator also attempted to compensate for the influence of these psychological needs by seeking a final product that reflected theoretical sensitivity.

Principles of Grounded Theory

Given the epistemological controversies that have developed over the life of grounded theory (Dey, 1999), and the importance of adapting research methods to the emerging situation, it may be more accurate (and instructive to the future researcher) to describe grounded theory in terms of a set of principles, rather than a list of steps. I have articulated these principles by unpacking the definition of grounded theory given earlier. These principles organize the presentation of method to follow.

1. The research question should be open enough to allow exploration rather than confirmation-seeking.

2. Recruitment of participants should be driven by the desire for depth of theory and fit of theory to situation, rather than statistically sound generalizability to a larger population.
3. Interaction with participants should be guided by the desire for depth of theory, and for theory to emerge from rather than be imposed on participants.

4. Theory-building should be systematically grounded in the participants’ perceived experiences through seven interrelated processes:
   a) articulating and setting aside of biases related to theory;
   b) fragmenting, comparing, and recombining data;
   c) defining concepts and relationships among concepts;
   d) developing higher-order explanations for perceived relationships;
   e) trying out explanations for fit with participant narratives;
   f) integrating explanations into a single theory focused around a single concept.

5. Practical implications of the theory should be spelled out.

6. The process of research and theory generation should be detailed.

Grounded Theory and the Research Question

The research question, now taking into account the change in terminology, is:

What theory can usefully explain how a set of experienced psychotherapists manage their reactivity in ways they deem successful?

Is grounded theory appropriate to answering such a question? Early conceptions of grounded theory emphasized entering into a field, or particular area of social interaction, with no preconceived ideas about the main events. This would be akin to acting as an anthropologist and setting aside ideas about the culture based on previous contact with or membership in that culture. However, the degree of prior knowledge or ability to focus on a specific type of
interaction based on that knowledge does not preclude the possibility of using grounded theory methods.

In the process of elaborating and disagreeing on the nature of grounded theory, Strauss and Glaser have bound grounded theory up in requirements and polemics. In essence grounded theory stands in contrast to ungrounded theory in that the former relies for input on systematically gathered and analyzed human experiences, rather than on unsystematically gathered and analyzed human experiences. Being systematic means being thorough (breadth) and following theoretical implications through to the end (depth).

Development of the Research Question

The research question has to be exploratory. I chose this question guided by two personal observations. First, based on my experience as a therapist and as a client in psychotherapy, I observed that therapists’ feelings toward their clients can have a significant influence on therapist behavior, both for ill and for good. I knew this on a theoretical level from my introductory understanding of psychodynamic psychotherapy, but the power of therapist reactivity struck me as important through my own experiences. Second, I wanted to study therapeutic success. I knew from my own self-critical tendencies and from the frequent bias of clinical supervision toward identifying and changing problematic therapist behaviors, that it is easy to overlook success as a source of learning.

The original research question is somewhat more specific than the research areas with which some grounded theory studies begin. However, the question was adequately open to allow for exploration rather than confirmation. The core category should emerge from the data, but this research question does imply a core category: countertransference management. The
relationships among categories that emerged from the data were examined at two distinct junctures to determine whether some other category might be at the core of the process (See Chapter XII).

The core category also went through some evolution. The term “therapist reactivity” was substituted for “countertransference,” for reasons explained at the beginning of this chapter. And incorporated into the meaning of “management” was the possibility of using reactivity therapeutically, based on the frequency with which participants described such processes.

Grounded theory is often used to explore processes that have never or rarely been studied before, such that the object of inquiry is the process as a whole. Psychotherapy has been studied a great deal, and many theories already exist to explain the overall process. Although the focus of this study is less broad, it retains enough complexity to be appropriate to grounded theory methods. The justification for this claim lies in the theory itself, in its coherence and nuance.

**Participant Selection Strategy**

The second principle of grounded theory is that recruitment of participants should be driven by the desire for depth of theory and fit of theory to situation. In contrast with quantitative research, which seeks to ensure generalizability of results through random selection from a population, qualitative research is more concerned with purposive sampling to engage participants who exemplify the phenomenon under investigation. Initially, however, the field was narrowed through a random sample of APA-affiliated psychologists who have been licensed for at least five years and lived within a two-hour drive of the investigator (who also conducted the interviews). From this sample, a nomination process was used. In a letter explaining the nature of the study, those selected using the above criteria were asked to nominate up to five colleagues
who they knew to be in practice for at least five years after licensure, and perceived to be highly effective therapists open to discussing personal aspects of their work. This nomination process generated 35 potential participants. Of these, 16 were selected based on number of nominations, years of experience, and gender distribution. All nominated therapists were then sent a letter announcing that they had been nominated by colleagues, explaining the nature of the study, and requesting participation. Follow-up phone calls were made as needed.

Of these 16, two declined because they worked primarily with children, and one declined out of concerns about privacy. Those 13 therapists who agreed to participate completed a demographic form that affirmed their years of practice since licensure, as well as ascertaining age, gender, partnership status, race/ethnicity, and theoretical orientation(s). An additional therapist, a social worker known to the investigator, agreed to a taped interview to assist the investigator in development of interview technique. Although this interview seemed to yield useful information, it was not included in the data because the therapist did not meet the criterion of being a psychologist. Another interview was not used because the participant described wholly unsuccessful reactivity management.

The remaining 12 therapists included seven females and five males. Ages ranged from 37 to 57, with mean age of 50; years of clinical experience ranged from 11 to 35, with a mean of 19 years; post-licensure experience accounted for approximately 75% of the total. All but one of the therapists was Caucasian; the exception was Puerto Rican-American. A diligent effort was made to recruit therapists of color in areas within driving distance of State College that might have more racially diverse therapists. The one therapist of color who participated did add a cultural element to the theory that would have been missing otherwise.
Theoretical orientations represented were cognitive (Therapist 10), cognitive-behavioral (Therapist 5), cognitive/eclectic (Therapist 2), developmental object relations/interpersonal and cognitive-behavioral (Therapist 6), eclectic (Therapists 11 and 12), existential, psychodynamic, eclectic (Therapist 1), gestalt, humanistic, eclectic (Therapist 7), humanistic: existential-gestalt (Therapist 9), humanistic, gestalt, feminist, eclectic (Therapist 3), and psychoanalytic/integrative (Therapist 8). Therapist 4 did not affiliate himself with a particular theoretical orientation. These self-designated orientations may have had an extensive influence on the grounded theory in that they may have helped to determine how participants understood and managed their reactivity, and how they presented these processes to the interviewer.

Theoretical sampling as described in the grounded theory literature is meant to be iterative. As the area of research inquiry becomes more refined, and as the developing theory is subjected to scrutiny through a search for examples that do not fit, further participants are sought. My desire to impose some practical limits on the research process, as well as the initial clarity of the area of research, led me to reject the additional step of adding participants during theory development. I did make initial sketches of the reactivity management process using groups of three interviews (selected through the order in which they were interviewed), then merged the four diagrams together. This process prevented me from minimizing diversity of experience at the outset in order to achieve theoretical coherence. Throughout the theory-building process, I attempted to remain aware of the possibility that the process as I understood could be otherwise. For example, just because many participants described how empathy played a role in reactivity management, I did not assume that empathy was a necessary factor, nor did I assume that it belonged at a certain point in the process, nor did I assume that all therapists
meant the same thing when they used the words empathy and compassion. This awareness allowed me to understand empathy and its part in the overall process in more nuanced ways.

**Interview Protocol Development**

The third principle is that interaction with participants should be guided by the desire for depth of theory, and for theory to emerge from rather than be imposed on participants. The research question guided development of the interview protocol (Figure 2, p. 76), which asked about the client’s presenting problems and background, the therapy relationship, the therapist’s reactions, client variables that evoked these reactions, effects of reactions on client or therapy, steps taken to be aware of reactions, methods of dealing with reactions, results for client or therapy of therapist coping with reactions, therapist attitudes toward personal reactions, and effects of the whole process on therapist development. Taken together, these question map quite well onto a paradigm introduced by Strauss and Corbin (1990), consisting of a central phenomenon, causal conditions, strategies for action in relation to the central phenomenon, intervening conditions, and consequences of the strategies.

One may question whether such a paradigm is leading in terms of theory-building, and also whether the questions in the interview protocol are leading in setting up concepts like triggers, coping efforts, and effects ahead of time. I would argue (see also Dey, 1999) that such concepts are inseparable from the notion of a goal-oriented process: If nothing initiates a process, nothing happens, and nothing comes of it, then it is not a process. A further corroboration that the theory is not predetermined comes in the richness of content within each area, and the extent to which content within each category hangs together conceptually.

**Figure 2: Interview Protocol**

In preparation for the interview, choose a client of yours who meets the following criteria:
A. Completed therapy within the past 12 months (the more recent the better).
B. Evoked in you personal reactions (e.g., emotions, thoughts, or behaviors) that made therapy challenging.
C. Ultimately made some therapeutic gains, from your point of view at least in part as a result of your efforts in dealing with whatever the client evoked in you.

The following questions will be asked in the course of the interview. Please allow yourself time to think about these questions before the interview. You may wish to put your thoughts in writing if you find this helpful.

1. How would you describe this client (demographic information, presenting complaints, family background, case conceptualization)? Please omit (rather than change) any information that could reveal the identity of the client.
2. How would you describe your relationship with this client (e.g., in terms of emotional climate, roles, working alliance, relationship patterns)? How did the relationship change over the course of therapy?
3. What personal reactions (e.g., emotions, thoughts, or behaviors) did the client evoke in you that made therapy challenging?
4. How were these reactions evoked by the client (e.g., client traits, behaviors, material discussed)?
5. How and when did you become aware of your reactions? What steps if any had you taken to develop this awareness of personal reactions (either in relation to this client, or more generally)?
6. If you tried to understand and/or change your reactions, how and when did you do so (i.e., in sessions, between sessions)?
7. What effects did your attempts to understand and/or change your reactions seem to have on the client and the therapy relationship? On therapy outcome?
8. What qualities in you helped you to successfully manage your personal reactions?
9. If there is anything you would do differently now, what would it be?
10. What is your overall attitude toward having personal reactions to clients?
11. In what ways if any did you grow personally as a result of dealing with your reactions to this client?

The questions were developed through awareness of theoretical and empirical literature, but were worded in order to avoid implying a theoretical bias. The phrase “personal reactions (e.g., emotions, thoughts, or behaviors) that made therapy challenging” (see Appendix A) was chosen in order to include both intrapsychic and interpersonal dimensions of CT. This choice might seem to risk eliciting responses from therapists that conform more to the totalistic definition of CT. As noted in Chapter II, this study is focused on the management of CT that
originates, at least in part, in the therapist’s own psychological nature or problems. However, I did not wish to exclude *a priori* more totalistic responses (e.g., frustration toward a passive-aggressive client) because it is quite possible that part of the CT management process includes distinguishing, as best as possible, between the contributions of the therapist and those of the client. This idea is also supported in the theoretical literature (e.g., Racker, 1957).

**Interview Procedures**

A number of elements in the interview process were aimed at helping the process of reactivity management as perceived by the therapists emerge, and do so without being overly shaped by the interviewer. The interview questions were provided one to two weeks in advance, reflecting the view of Hill et al. (1997) that when participants have the opportunity to reflect upon questions in advance, they are more likely to provide thoughtful responses. The questions were intended to act as cues to help the participants construct a narrative account of CT management as it applied to a particular case. Participants were encouraged to think about the interview questions in advance and to take notes if this was helpful in their own judgment.

The interviews were conducted face-to-face by the investigator, typically in the rooms where participating therapists conducted therapy. The interviews were recorded on audiotape and lasted 45 to 75 minutes, with one exception (Therapist 10): a 30 minute interview was conducted as a replication after the first attempt failed to record. Notes from the first attempt supplemented the investigator’s understanding. The interview for Therapist 2 was conducted over two occasions. The interviews took place on the following dates: 10/03/02 (Therapist 1), 10/5 and 11/2 (Therapist 2), 10/5 (Therapist 3), 10/8 (Therapist 4), 10/9 (Therapists 5 and 6), 10/10
Interviews were guided by the protocol questions, with further questions added to follow the participants’ lead as the conversations evolved. Answers to protocol questions were often embedded in therapist narratives and therefore didn’t need to be asked. Interviews were conducted as methods of eliciting rather than imposing meanings, through a stance in which shared meanings were not assumed and gaps in the story formed the basis of further questions. Interviews were transcribed by two professional transcriptionists, with the exception of one interview, which was transcribed by the investigator in order to develop a feel for the difference between voice and written text. The transcriptionists’ understanding of the confidential nature of the data was affirmed through a brief discussion. Transcripts were checked for errors by the interviewer.

Following development of a complete theory, participants were provided with narrative summaries of their cases, and narrative and diagram versions of the grounded theory. Follow-up questions (one to two for each participant) were asked to clarify ambiguous areas or fill in gaps. The therapists were invited to contribute to theory revision and refinement, and to revise narratives of their own cases, either in writing or through phone conversations.

**Researcher Team Recruitment and Preparation**

A research team was convened, and members were replaced as required by their competing priorities and life events. Team members had varying exposure to literature on countertransference, and a high level of exposure to theory, research, and practice of psychotherapy. The investigator had extensive exposure to both research and theory on

(Therapist 7), 10/19 (Therapist 8), 10/24 (Therapist 9), 10/28 (Therapist 10), 11/2 (Therapist 11), and 11/7 (Therapist 12).
countertransference and its management. Glaser and Strauss (1967) have warned against theoretical prejudice caused by familiarity, however Dey (1999) argued that the originators of grounded theory were naïve in denying the universality of pre-existing constructs that guide interpretation, no matter what familiarity researchers have with constructs from the professional literature. Researchers were briefed on data analysis procedures, confidentiality, and consensus-building without sacrificing dissent and debate. The process of consensus-building was reviewed periodically to assure that no one gained undue power and influence over the process.

Theory Building

Theory building is the heart of the grounded theory enterprise. To be most effective it must be taken with a combination of unstructured exploration and logical rigor. The steps involved in theory-building bear repeating here:

1) articulating and setting aside of biases related to theory;
2) fragmenting, comparing, and recombining data;
3) defining concepts and relationships among concepts;
4) developing higher-order explanations for perceived relationships;
5) trying out explanations for fit with participant narratives;
6) integrating explanations into a single theory focused around a single concept.

Bracketing Biases
All of the beginning team members, including the investigator, wrote down their assumptions about what theoretical relationships would be discovered. Early discussions among team members focused on several important theoretical questions in which individual bias seemed operative. Once the investigator shifted into grounded theory, several known constructs from interpersonal and psychodynamic theory seemed useful in theory-building, some of which were used by participants to explain their own experience. Two criteria were used to determine whether such constructs could be said to emerge from the data rather than doing violence to participants’ experiences. First, if a construct from one therapist (e.g., contact or projective identification) was used to understand the experience of another, care was taken to ensure that no differences stood out that invalidated the equivalence. Second, if a construct (e.g., interpersonal stance or use of self) was used to divide a category into subcategories, then the relationships of those subcategories to subcategories in proximal categories were examined. The construct was determined to be relevant if differences in subcategories flowed through the process, from category to category.

Fragmenting, Comparing, and Recombining Data

All transcripts were divided into meaning units, with these divisions remaining tentative until their membership in conceptual categories became clear. These categories, called “domains” in CQR and “categories” in grounded theory (the latter term will be used), evolved further in the process of data analysis, through a consensual process of discussion and re-examination of the data. Categories were essentially responses to the questions, “What step in the process is this therapist talking about here?” and “Do all of the therapists engage in this step, and if not, is it only an example of a more inclusive concept?”
Categories may be divided or merged, added or deleted; this progression is documented in Chapter XII. Categories are not necessarily mutually exclusive in that they may blend into each other, with meaning units assigned to both; however too much overlap reflects conceptual confusion. All data units from transcripts must be assigned to at least one category. An “Other” category was used for data that were not relevant to the topic such as discussion of the interview logistics, interviewer statements and questions, and asides. A “Context” category was also used to include any information about the client, therapist or therapy that did not have any bearing (at least not any discussed by the therapists) on reactivity management or therapy outcome.

The initial phase of assigning data units to categories was accomplished by each member of the research team independently going through the transcript of a single interview. A data unit can range from a phrase to several sentences, and is based simply on its relationship to one or more categories, as in grounded theory (Strauss & Corbin, 1998). Data units are therefore not based on speaking turns.

Following independent data coding, the team met to discuss the assignment of each data unit until a consensus version was achieved whose logic could be defended to a person outside the process. Some category titles were revised at this time and at other points in analysis and auditing. Once category assignments and titles were agreed upon, three more transcripts were coded by the entire team in the same manner as the first, to ensure clarity on the range of the categories. Decision rules were developed for data assignment to categories (see below). The remaining eight transcripts were coded by rotating pairs of team members (Gelso, Hill, Mohr, Rochlen, & Zach, 1999).

Decision Rules for assignment of meaning units to categories:

1. A meaning unit may consist of more than one idea so long as the ideas belong to the same domain and would lose some of their meaning if separated.
2. Text from the interviewer may be coded as other than “OTHER” when it adds meaning agreed upon by the therapist and not repeated by the therapist.

3. Double and triple coding may occur but should be accompanied by an explanatory memo.

4. The evidence that a meaning unit should be coded in a certain way, i.e. that the therapist viewed it as belonging to a certain domain, may be found elsewhere in the transcript, and should be accompanied by an explanatory memo.

Defining Concepts and Relationships Among Concepts

Development of categories sets the broad outline for the grounded theory, but could be seen as mapping well onto the axial coding paradigm offered by Strauss and Corbin (1990): a central phenomenon, causal conditions, strategies for action in relation to the central phenomenon, intervening conditions, and consequences of the strategies. The only differences (see Chapter IV) were (a) that the central phenomenon and the strategies each had separate categories for their consequences, (b) the intervening conditions were entirely facilitative rather than hindering, due perhaps to the interest ahead of time in only examining cases perceived as successful.

Because the process of reactivity generation and management follows the broad paradigm for any goal-directed social-psychological process, the categories and their relationships are quite skeletal and uninformative. Therefore it is not until meaning units have been explored for subcategories, dimensions, and relationships among them that the meat of the theory can be delineated.

Theory building consists of several interactive elements: constructing core ideas (a CQR step that added theoretical sensitivity to the grounded theory process); identification of subcategories, discovery of relationships among subcategories across categories; identification of
dimensions within some subcategories; and discovery of influences of dimensions on relationships between subcategories across categories.

**Constructing Core Ideas**

In order to help understanding of reactivity management to emerge, the meaning units assigned to each category can be concentrated into phrases that retain their essential meaning. Several guidelines are provided by Hill et al. (1997) for the construction of core ideas. The context of the entire case, in this research the therapy relationship being discussed, is important in this abstracting process. The category to which a data unit has been assigned is also crucial to its interpretation. A third point in constructing core ideas is to remain close to the content rather than imposing theoretical constructs or inferences.

Each team member independently constructed core ideas for a single interview and then discussed these as a team until a consensus was reached. Pairs of team members each worked on one further interview in the same manner, resulting in three interviews (1, 2, and 4) with core ideas. Following core idea construction, the team reviewed the data to determine whether consistent decision rules had been applied for assigning meaning units to categories. The investigator also developed summaries of the content of each category for the first eight interviews.

It is at this stage and the stage of developing categories that personal biases are first likely to enter in a significant way. Team members (including the investigator) asked each other periodically about their personal reactions to transcripts as one way of becoming aware of biases and reducing their influence. During core idea development, meaning units were sometimes
reassigned from one category to another, as their meaning was elucidated (Hill et al., 1997). Such reassignments were conducted across all interviews as necessary.

**Identifying Subcategories**

The first task of analysis after identifying categories is to identify subcategories within them. Subcategories are particular ways in which the category under consideration varies in response to the larger process. For each transcript, the investigator grouped all of the meaning units (and core ideas if completed) by category in a new document. For example, all of the meaning units designated as examples of *therapist development* were placed together under that heading. As a result, in addition to twelve transcripts there were now twelve documents of quotes from transcripts listed under category titles, with categories in the same order across documents to facilitate cross analysis and the identification of subcategories.

Subcategories were identified by asking the questions, “What do these meaning units (or core ideas) have in common with each other and how do they differ from each other?” and “Are there other ways of dividing up this category that work better to explain differences that have an impact on the therapy process and outcome?”

These subcategories were then subject to revision until they appeared to exhaust all the possibilities presented by the meaning units while grouping these differences in clinically and theoretically significant ways. Clinical significance was determined by imagining how a therapist might use recognition of subcategories to guide reactivity management. Theoretical significance was determined by examining whether subcategories might be derived from the “causal powers” of the therapist, the client, and/or the “structural conditions” of the therapy relationship.
A causal power is a capacity for action, and a structural condition is a aspect of an environment that shapes the potential impact of such action. These terms are borrowed from Dey (1999) and are pre-theoretical in that they merely describe what is possible by definition. As an example, take the subcategory of client interpersonal history in the category of causes. Does a person have a history of interpersonal relationships and subjective reactions to them that influences the present? Certainly, or one’s everyday definition of “person” must undergo a radical alteration, such that a person makes up responses to interpersonal situations on the spot, with nothing to draw from. This subcategory combines structural condition and causal power.

Determination of theoretical saturation is highly subjective. Subcategories were determined as much as possible by grouping the data and describing the underlying unity in fresh language, rather than by applying pre-existing theory. If borrowed concepts were used, they were carefully compared to therapist narratives for goodness of fit.

Exploration of Properties

Properties are attributes of processes, people or things referred to in meaning units belonging to categories or subcategories (Dey, 1999). If not described directly by research participants, these attributes are identified by analyzing interactions. For example, within the category of reactivity management, the subcategory of experiential change may be viewed as having properties like transcendence of limiting interactive patterns and valuing contact with self. In the data analysis chapters, properties are not identified as such, but are woven into the descriptions of how processes function. Categories and subcategories identify the steps in the reactivity management process (the “how”), and properties describe the nature of these steps. It is through knowing the properties of processes that we know why they occur the way they do –
not in the sense of a set of refuted null hypotheses, but in the sense of a cohesive explanation that fits all of the data and arises from the internal necessity of the situation.

**Discovery of Relationships Among Subcategories**

The presence or absence of causal sequences is dictated by the interaction of properties. For example, therapists’ *supportive relationships* have the property of emotional safety, and this property interacts with the emotional reaction property of *reactivity* to lead to therapist use of such relationships for venting and containing emotion. Not all therapists attribute the same properties to the same categories or subcategories. One might view this inconsistency as problematic; however, it simply indicates complex interactions. A therapist who needs ventilation and containment of intense emotions seeks safe places to do so; a therapist who needs validation of a new approach to a client will find validation as a property of supportive relationships. The validity of such interactions comes in the reader’s recognition of their internal necessity, through having experienced or being able to imagine experience the same conditions and needs.

**Integrating Explanations into a Single Theory**

Analysis across therapists required an exhaustive search for patterns in the data, both in terms of similarities and differences. Higher-order explanations respond to questions about how and why influential constructs operate, and the extent of their influence. These explanations are the final building blocks of theory, and as they develop they gather around a central phenomenon that becomes clear through these interrelated explanations. Such explanations are generated by
trying on hypotheses that are suggested by observation, logic, personal experience, or exposure to literature on the topic.

The higher-order explanations work together to explain a single phenomenon of interest: in this case, therapist reactivity management. The overall theory answers the question, “When these therapists manage their reactivity in ways they deem successful, what are they essentially doing?” To answer this question, one must unpack the terms manage, reactivity, and successful. This unpacking process requires that the meanings be discovered not by asking participants for definitions, but by asking them to tell a story. The story doesn’t directly contain the definitions of these terms, just as novels don’t announce their themes; they just play them out. Yet the themes are there, waiting to be put into words.

**Charting Results**

The grounded theory, with putative causal processes linking categories, was diagrammed in several flow charts (Creswell, 1998; Strauss & Corbin, 1998). These flowcharts evolved over several versions as they were tested against individual narratives, as the auditor and participants provided feedback, and as concepts were clarified. In deciding whether to include variant responses in the reactivity management process diagram, the range of participants’ experiences was weighed against the explanatory clarity of the model.

**Narrative Accounts**

A narrative of each case was written by the investigator as an individual example of the grounded theory in action. All of these accounts are included in Chapter IV, as is a narrative synthesis that includes commonalities and variations across cases. The individual and overall
accounts were revised when participants provided corrective feedback or augmented their narratives. The narratives were useful in testing the completeness of the grounded theory in covering all of the possibilities of therapist reactivity and its management.

**Participant Checking**

Narrative accounts for individual cases, the narrative synthesis, and the flowchart (at that point the flowchart incorporated relationships among many subcategories that were subsequently spread out among several charts) were sent to the corresponding participants. Any changes or additions they recommended in their individual accounts or the grounded theory itself were incorporated.

**Auditing**

Auditing, a feature of CQR as well as other qualitative methods (but not a requirement of grounded theory) was utilized as a counterbalance against team conformity of thought as well as bias or blindness in the investigator. Although consensus is useful in minimizing individual bias, the dynamics of the research team may be such that conformity outweighs judgment and is invisible to the members. The role of the auditor is to provide an informed but independent perspective (Gelso et al., 1999; Hill et. al, 1997).

For several interviews (see Chapter XII for the transition in methodology), the auditor compared the data and the core ideas. The auditor could then critique any of the following: the assignment of data to categories, inclusion of important category material in core ideas, conciseness of wording in core ideas, and accurate reflection of data in core ideas. The auditor’s comments were returned to the team, which considered each comment on its merits. Those
comments that seemed appropriate formed the basis of revisions (also subject to consensus) to be returned to the auditor along with the original comments. The auditor could then have the opportunity to argue for any recommended changes that were rejected, and a meeting between team and auditor could be scheduled (though it wasn’t necessary) to resolve any disagreements (Hill et al., 1997).

Auditing continued through each stage of the theory building process in like manner. Auditor feedback and investigator responses are detailed in Chapter XII. The roles of auditor and thesis advisor were somewhat merged; the primary role of the auditor seemed to be to point out conceptual confusion and omissions.

**Meeting Criteria of Trustworthiness**

By what criteria should a grounded theory study be evaluated? Strauss and Corbin (1990, pp. 254-256) offered six criteria by which to judge the “empirical grounding” of a grounded theory. These criteria are presented as a series of yes/no questions; as such they do not define how to judge the extent to which criteria have been met. In the audit of the research process (Chapter XII), these concerns are addressed in depth. In the meantime, these criteria are offered now to assist the reader in thinking critically about the grounded theory as it is encountered.

1. Are concepts generated?

2. Are the concepts systematically related?

3. Are there many conceptual linkages, and are the categories well developed? Do categories have conceptual density?

4. Is variation built into the theory?

5. Are the conditions under which variation can be found built into the study and explained?

6. Has process been taken into account?
In their second edition (1998), Strauss and Corbin added two more criteria: “Do the theoretical findings seem significant, and to what extent?” and “Does the theory stand the test of time and become part of the discussions and ideas exchanged among relevant social and professional groups?” Both of these criteria address applicability; again the reader is urged to read interactively, not only in the sense of being skeptical (summed up in the question, “How do I know you know that?”) but also in the sense of being generative (“What possibilities does this give me?”).

Dey (1999, pp. 244-246) offers further criteria for the investigator to follow. First, “Some Ways of Grounding Theory Conceptually”:

- Consider its consistency with other theories
- Clarify the connections between concepts and the grounds for inference
- Identify errors, ambiguities, and exceptions in the analysis
- Assess alternative explanations consistent with the data
- Provide an audit of the emergence of theoretical ideas

Second, “Some Ways of Grounding Theory Empirically”:

- Consider the (in-) consistency of the emergent theory with evidence from other research done in the field
- Make more explicit the conceptual assumptions that underpin observation
- Take account of different modes and levels of categorization

All of these recommendations were taken, and are considered in the integration with literature (Chapter IX), the audit (Chapter XII), or the data analysis itself (Chapters IV through VIII). Perhaps the weakest criterion is the consideration of alternative explanations. This step was pursued early in the data analysis, but beyond a certain point of theory elaboration it became
difficult to imagine other possible explanations. This observation either highlights the importance of triangulation among perspectives, or reinforces coherence as a criterion of truth.

**Determining Stability Across Sample**

Hill et al. (1997) recommend setting aside a few cases prior to data analysis, then seeing whether they generate substantially different results. If not, stability of findings is considered achieved. If changes do occur, then new participants must be sought until they do not seem to contribute to theory-building. However, if the sample happens to be homogeneous with regard to CT management, stability may be achieved without any guaranty of having exhausted possible patterns in the phenomenon. Too much heterogeneity may imply that the phenomenon of CT management has not been approached at a high enough level of abstraction to see commonalities within the variety. Given these limitations, the stability checking process seems largely artifactual and unlikely to improve or make more convincing the study’s findings.

One aspect of grounded theory that guards against theoretical bias is that the theory development process stays close to the data, in that it is essentially a search for a common process with variations across the sample. However, in a profession in which theory plays a large role, participants are likely to contribute interpretations of their own processes that bring in theoretical constructs. In these cases several steps were taken so that readers were not overly constrained away from their own potentially fruitful interpretations. The fit of such constructs to other therapists’ experiences was questioned. How well the constructs fit with the interactions the same therapists described with their clients was also considered. Additionally, it must be
noted that what is being studied is the participants’ understanding of their own experience, such that using their own theoretical constructs is legitimate and even required to represent their subjective experience. This being said, a distinction sometimes had to be made between theoretical constructs that were used as part of the reactivity management process, and those used to explain it after the fact. Often these seemed to be the same.

**External Validity**

Once the grounded theory was completely articulated, it was compared to existing theoretical and empirical literature for convergences and divergences that offered further grounding and suggested future directions for research and theory development. Implications at a more abstract level concerning the nature of psychological growth are also considered in Chapter IX. Applications to practice and training are explored in Chapter XI and offer further evidence of the potential utility of this grounded theory of therapist reactivity management. Further testing of external validity depends upon further research or the application of the grounded theory to clinical practice.
Chapter IV

SUMMARY OF FINDINGS:

A GROUNDED THEORY OF THERAPIST REACTIVITY MANAGEMENT AND USE

Countertransference is the best of servants, but the worst of masters.

-- Hannah Segal (1977)

Introduction

In this chapter the overall theory of therapist reactivity management and use is presented. Although in reviewing the literature I have naturally employed the term “countertransference,” from this point forward I use the term “therapist reactivity” (and sometimes “reactivity,” when it is clear that the therapist and not the client is being discussed). In Chapter III my rationale for this choice was explained. This explanation also helped to locate the boundaries of meaning for this term. A number of other terms that appear frequently in the data analysis are defined at the beginning of this chapter, setting up a network of concepts necessary to understanding the theory as a whole.

Narrative summaries of all twelve cases are presented next, before the theory, because they will allow the reader to understand the theory in context and see how it fits with the data. A narrative synthesis of all twelve cases helps to establish the grounded nature of the overall theory. Flowcharts of the process of reactivity management (Figures 4, 5, 6, 7, pp. 122-125) reflect the narrative synthesis in visual form.

The reader is encouraged to read the case summaries interactively, thinking about what they seem to be saying about the process of reactivity management and use. The reader is also reminded that while the criteria of fit and applicability are important to judge the grounded
theory presented here, the complex nature of human interaction does not allow any theory about it to be definitive or complete.

Key Constructs

A grounded theory is a network of relationships among constructs, all of which are abstracted from individual experiences of the same phenomenon. Before outlining the conceptual relationships that cumulatively describe the process of therapist reactivity management and use, I will define the constituent constructs related to therapist and client reactivity, reactivity management, and therapeutic responsiveness. These definitions are my own and do not necessarily match definitions in the literature. Instead, the definitions offered here are intended to map as closely as possible onto the twelve therapists’ experiences as they unfolded in the interviews.

Valuing Contact: Interaction between two people in which one or both experience the existence and value of self, other and the relationship. A lack of valuing contact may be experienced as abandonment and shame.

Interpersonal history: Past experiences of interpersonal interaction, mediated by psychological processes and social variables, that have had an impact on how the person attempts to meet psychological needs and interact in interpersonal relationships in the present.

Psychological Need: A condition required for subjective well-being. This condition is often related to valuing contact with self and others. The absence of this condition motivates the
person to engage in behaviors toward self and others that are meant to achieve well-being or at least minimize suffering.

**Psychological Wound**: An aspect of interpersonal history that is currently experienced as suffering (the opposite of well-being) when it is in awareness. The wound is often related to a chronic disruption of valuing contact that resulted in psychological defenses and interpersonal tendencies that reduced the possibility of contact in order to reduce suffering. The wound may be inadvertently re-experienced through repetition of behavior meant to minimize suffering.

**Cognitive-emotional reaction**: Interrelated thoughts and feelings resulting from the anticipated or actual satisfaction or frustration of a psychological need, or re-experiencing of a psychological wound. Interpersonal history, psychological defenses, interpersonal tendencies, and present interaction with others all may play a part in activating or mediating the reaction. The reaction may first be experienced as a sensation disconnected from awareness of thoughts, feelings, psychological needs or wounds.

**Therapist Reactivity**: The activation of a therapist’s psychological needs and/or wounds, rooted in the therapist’s interpersonal history and psychological functioning, expressed through cognitive-emotional and sometimes behavioral reactions within the therapy relationship, and activated by the client’s characteristics and/or behavior.

**Mutual Reactivity**: A cyclical interaction between therapist and client, in which their behavior activates each other’s psychological needs and/or wounds in a mutually escalating manner.
Psychological Defenses: Various psychological means of reducing suffering, such as dissociation, deflection, retroflection, introjection, projection, and projective identification. These are means of avoiding contact with aspects of self or others that may be associated with suffering. Specific defenses are defined in context.

Interpersonal Tendencies: Ways that a person acts toward others that are learned in early relationships and that tend to avoid anticipated suffering but in the process reduce opportunities for valuing contact. Specific interpersonal tendencies are defined in context.

Development: A process of learning to express one’s individuality in a manner that establishes and deepens relationships characterized by valuing contact.

Responsiveness: The ability to respond to a person with a psychological need or wound in such a way that creates an opportunity for the person to further develop. Not necessarily synonymous with the ability to meet the need, given that development may occur when needs go unmet.

Congruence: Agreement between the therapist’s cognitive-emotional and behavioral responses or reactions. Lack of congruence is often perceived by the client as a failure of contact and reduces the possibility of contact. Congruence, in contrast, may increase the possibility of contact.

Empathy: A form of valuing contact in which what is valued and experienced by the therapist is the client’s or the therapist’s own suffering related to psychological wounds and/or needs.
Transcendence: The act of changing one’s relationship to one’s self, psychological needs, and/or psychological wounds, often through a corrective experience, such that one can become responsive rather than reactive to another person.

Containment: The act of empathetically identifying and setting aside reactivity, such that one can become responsive rather than reactive to another person.

Use of Self: The therapist’s deliberate introduction into therapy of any aspect of his or her experience that allows the client to perceive the therapist’s humanity beyond the therapist role.

Corrective Experience: A therapeutic interaction that one or both parties experience as different from a mutual reactivity cycle; the new interaction thus challenges development-limiting beliefs about self and relationship that were instilled by psychological wounds.

Wounded Healer: A therapist, who through empathetic, valuing contact with his or her own psychological wounds and needs, becomes able to help a psychologically wounded client gain in awareness and acceptance as well, in part through use of self.

Relational Expert: A therapist who through awareness and acceptance of a client’s psychological wounds and needs and how they play out in the therapy relationship, is able to help the client change ways of relating to self and others.
Narrative Summaries

The following summaries focus on therapist reactivity and its management and use. Some elements of interviews, such as background information about clients or therapeutic interventions that did not pertain to therapist reactivity, are omitted.

Interview 1

The therapist’s history with an absent, depressed mother led her to be overwhelmed in the presence of rage, because she could not cope with her own when as a child she felt psychologically invisible. The client had a history of invalidating relationships that left her feeling invisible, hurt, and angry, replicating these relationships in a self-defeating search for validation consistent with a diagnosis of Borderline Personality Disorder. The therapist did not want to confront her own hurt and anger at a deeply experienced level, but the client’s projective identification (trying to inculcate her own anger in the therapist by being hostile and demanding) pulled the therapist toward experiencing this hurt and anger. This led the therapist to be incongruent, to say caring things but be reacting to the client’s rage with her own anger and emotional paralysis internally. The client then became more enraged at the therapist’s lack of compassion, in turn increasing the threat to the therapist and her lack of congruence. This cycle threatened the therapy relationship and kept the client stuck in a reactive, defensive stance.

The therapist became aware that she lacked empathy for the client and that this manifested as incongruent therapeutic communication, i.e. empathetic statements that lacked authenticity. The therapist also realized she wanted to get her client to stop being angry and demanding, rather than being with the client in experiencing where the anger and demands were coming from. The therapist decided to deal with her lack of empathy and consulted with a trusted
colleague with whom she had an ongoing consulting relationship. The therapist knew of a Buddhist meditation practice called *tonglen* that especially worked with transforming negative feelings toward self and others into compassion. The therapist practiced *tonglen* outside of sessions and inside. As a result of consultation and *tonglen*, the therapist understood the origins of her discomfort with anger. This awareness and *tonglen* helped the therapist empathize with both her own reactions and those of her client.

The therapist was able to communicate genuine compassion and hold her client’s pain. This allowed the client to develop a trusting relationship with her, and to begin to have compassion toward herself. The therapist also taught her client a modified version of *tonglen* that facilitated compassion toward self and improved the client’s ability to form relationships with others. These capacities helped the client weather a worsening of biological symptoms of her illness.

The therapist learned to respect and pay attention to subtle emotional reactions; she also became more confident in treating clients with Borderline Personality Disorder. *Tonglen* influenced the therapist’s overall practice and personal development in helping her be more deeply compassionate toward clients and helping her accept and transform her reactivity.

**Interview 2**

The therapist felt very comfortable in his relationship with his own daughter the same age as the client. The client intensely sought a replacement for her recently deceased father. The therapist was moved by her trauma and was at risk for losing some of his therapeutic effectiveness by acting more as a father than a therapist. Perhaps as a result of blurred boundaries the termination wasn’t clear, although the therapist generally viewed termination as
gradual. Also perhaps more focused work was slowed by therapist’s initial acceptance of a more fatherly role, although the client may have needed a parent figure while coming to terms with her loss.

The therapist was aware from the beginning that the client might see him as a father figure to replace her deceased father, and that he was very comfortable in the role of father to a young adult daughter. He therefore worked actively from the beginning to sort out in his mind which fatherly urges on his part should be acted on in the client’s interest, and which should be withheld in the client’s interest. The therapist shifted over time away from the father role and toward the therapist role, but always avoided contact outside the therapy hour, reminding himself of the negative consequences of giving in to the client’s wishes and his own urges. A past experience of not keeping boundaries clear helped the therapist in this regard. The therapist was also aware of needing to let go of the client as she gained autonomy, and accept her reduced need for support.

As the client stabilized, the therapist discussed the limits of the therapy relationship and the difference between this and being a father, while affirming client’s worthiness as a daughter, leading client to take stock of her growing self-sufficiency. The client also came to recognize her image of the therapist as a parent was illusory but had been useful. She came to increasingly trust herself in making decisions and adjust to her loss.

Interview 3

Due to her sensitivity to abuse trauma rooted in her own abuse history, and lack of experience with such a dissociative client, the therapist was doubtful of her ability to make safe contact with the client. The therapist unwittingly abandoned the client, who was stuck in
dissociative silence but really wanted the therapist to draw her out. This abandonment, as well as
the client’s basic faith in the therapist from group work together, led the client to rage at the
therapist, which overwhelmed her due in part to her own abuse history.

The therapist scheduled her client after lunch so she could have time to prepare mentally
for the challenge. She didn’t think about the client so much as take down time. She became
aware of her fear of being invasive yet wanting to make contact, and decided to shared her
dilemma with the client, who asked that she be more persistent in making contact and expressed
her anger at feeling abandoned. The therapist also had to manage her fear of the client’s anger by
connecting this fear to her own history and recognizing that the client was not a threat and
needed the therapist to receive her anger. The therapist’s previous therapy helped her not be
overwhelmed by reactions connected to her own history. The therapist’s gestalt training helped
her focus on making contact and obstacles to contact, while also helping her to tolerate the
intensity of the therapy. The therapist also relied on the client’s faith in her and in the process
when she herself had doubts. The therapist talked positively to herself about how hard she was
working and what a good job she was doing.

As a result of this therapy the therapist learned how difficult clients’ anger could be for
her. She also gained in overall self-confidence after achieving hard-won therapeutic success.

Interview 4

The therapist had a long history of being highly controlled in situations that could be
angering. This was a cultural as well as a professional adaptation. In family sessions with the
therapist, the client’s mother and stepfather became increasingly verbally abusive, leading the
therapist to maintain his professional identity as unreactive, though internally he felt defensive
and angry. The client’s parents reacted to this incongruent response by escalating. The therapist reacted by not reacting, leading the parents to withdraw their son from therapy.

The therapist became aware of feeling intensely angry but under-reacting. Being a believer in consultation, doing so regularly, and having an expert family therapist with whom to consult, the therapist decided to consult about the impasse. Through consultation he identified his tendency to under-react and its origins in compensating for his history of overreacting, and in trying to fit into White and professional society that react negatively to the stereotype of an emotional Puerto Rican. He also recognized that fear of appearing defensive was preventing him from making his case for his interventions in an assertive manner. He became aware that his client’s mother’s and stepfather’s threats of legal action and their status as mental health practitioners were intimidating and contributed to under-reacting. Through consultation the therapist was able to gain confidence in his approach to the client and legitimize his feelings of anger. He was able to rehearse his responses and channel his emotional response into appropriate messages, taking extra time before family sessions to review his plan.

The therapist was then able to set limits on the mother’s and stepfather’s attacks and confront them assertively and congruently with the results of the counseling. He was also able to use his reactions to the stepfather to illuminate how his client might feel toward his stepfather when confronted in the same way. Although the therapist transferred the client in order to protect himself legally and because the mother and stepfather were intractable, they did stop escalating their verbal attacks and did not further harass the therapist. In future cases the therapist did find it easier and more effective to be more open with reactions.
Interview 5

The therapist grew up as a super-responsible oldest son. He therefore felt very guilty and remorseful after lapses in attention and understanding triggered feelings of abandonment in his client that were rooted in his childhood with a schizophrenic mother.

Once the client confronted the therapist with his lack of understanding, the therapist became aware of and realized he had to process his strong reaction. Through reflection about the experience of being human, the therapist recognized the role of his history as a super-responsible oldest child and was able to see that he was being too hard on himself and forgive himself. By offering a genuine apology and expressing his commitment to the client in spite of his failure, and by connecting the intensity of his client’s reaction to his history, the therapist showed his client that a misunderstanding could happen even when someone cared, and that relationships can be repaired rather than ending in abandonment. This experience helped the therapist understand that rifts in therapy relationships can lead to greater contact. The experience also had a lasting, humbling impact in teaching the therapist to accept his human imperfection.

Interview 6

The therapist had a need to see results and feel effective, as well as experiencing relationships that are reciprocal. The therapist felt put off by the client, initially viewing him as narcissistic and therefore unable to form a relationship that was not exploitative. The therapist grew impatient and pushed the client toward goals, at the same time de-emphasizing the therapy relationship. The client reacted by continuing to externalize responsibility for problems. His ability to relate to others didn’t move forward.
The therapist was aware from the beginning of her frustration, and soon decided to consult with her Object Relations training group. Through consultation she came to understand the client as schizoid rather than narcissistic (i.e., unskilled at and fearful of relationship, rather than exploitative). The therapist became more empathetic, more patient and less anxious for results, continuing to get validation from her training group that she was on the right track. She gradually shared her genuine regard for the client as a means of helping him experience safe emotional intimacy. She also became aware that she was attracted to the client or at least to the feeling of intimacy, and had to work at setting aside her needs for reciprocity and esteem that came with this intimacy, so that she remained attuned to the client’s needs and reactions. She took a more humble stance in letting the client teach her about his needs by paying close attention.

As a result of this therapy relationship the therapist grew to have a “deep experiential appreciation for the schizoid complex and their often unrecognized need for relationship” (personal communication, January 2004).

**Interview 7**

Due to her mother’s reaction to having a stillborn child when the therapist was two, as well as other factors, the therapist had a history of not feeling cherished. She also felt overwhelmed by the impact of her divorce several years before. The client had a severe abuse history and resulting dissociative disorder, expressing itself in almost complete silence in therapy. Together these factors led the therapist to wish for respite and feel overwhelmed and frustrated, as well as doubting her ability to help others. The therapist identified strongly with the client’s psychological wounds and helplessness, and had some difficulty joining with the client
out of fear of getting lost in a merger of her experience and the client’s. In frustration at her client’s silence the therapist would become almost punitively silent at times. This was a repetition of the perpetrator-victim relationship for the client. The therapist was struggling to stay present but really felt like sleeping. The client remained disengaged so long as she didn’t feel the therapist joining her.

The therapist identified the challenge of responding to a virtually silent client and her reactions of frustration, feeling deadened, and feeling overwhelmed. She consulted with the client’s previous therapist to verify that these reactions were elicited by the client and informative about the client. The therapist connected her feelings also to her own history of loss/not being nurtured and used this awareness to empathize with client. Through therapy, personal beliefs and introspection, the therapist came to accept her own emotional vulnerability, allowing her to be with rather than feel impatient with the client. The therapist also engaged in self-care, e.g. naps, reading, to be energized for sessions. The presence of an intensive case manager allowed the therapist to feel less overwhelmed by the client’s life problems and focus on the therapy relationship. The therapist shared some of her vulnerabilities and their origins with the client to help the client trust her. Rather than pushing or withdrawing, the therapist also articulated and expressed empathy regarding the client’s dilemma of needing to be seen yet fearing to be hurt.

The client appeared to increasingly trust the therapist as shown in eye contact and discussion of suicidal feelings.

The therapist became more aware of her psychological wounds on an emotional level, and deepened her appreciation of what it means to be a wounded healer. She also confirmed her individual path as a psychologist who works with intuition and touch.
Interview 8

The client was a prim and proper older woman who presented with anxiety and discussed her problems from a distance, avoiding directly expressing feelings or discussing sexual issues. The therapist immediately saw similarities between the client and his own mother toward whom he had ambivalent reactions of wanting to provoke and please, leading him to avoid intimate subjects like the client’s sex life, relationship with her husband, and the therapy relationship itself. The client’s anxiety and ability to relate effectively didn’t make significant improvement so long as the therapist went along with her in avoiding these issues.

The therapist identified his conflicting urges toward the client as based in her similarity to his mother, and decided he needed to sort out his reactions to make real progress. The therapist’s tendencies to be slow to act out feelings and deliberate in thinking about them were helpful. He felt that his drama with his mother was already worked through and therefore could separate his own story from the needs of the client. He was then able to bring up topics that were uncomfortable but in a non-provocative manner, meeting her as an equal. The therapist also shared his responses to the client’s emotional openness vs. being closed. The client was able to reduce anxiety as well as experience emotional connection to therapist, and generalize this to improving her relationship with her husband.

Interview 9

Both therapist and client grew up with critical mothers and were rewarded for their intellectual prowess without having their emotional life validated. The client was a depressed man who didn’t know himself, had developed a false self, and was unhappy in his marriage. The client avoided intimacy in two ways: first by idealizing the therapist, then by challenging the
therapist to a debate. The therapist, first because he felt complacent in having his self-esteem boosted, later because his self-esteem was threatened, and finally because meaningful contact with the client exposed underlying shame, at times fell into providing insights and arguments rather than meeting the client as another human being. Therapist and client then colluded at in avoiding contact, delaying the client’s development of a sense of self in relationship.

Partly due to self-awareness cultivated through past therapy, the therapist became aware of his internal reactions and behaviors toward the client. The therapist recognized these behaviors as deflecting intimacy and avoiding shame. The therapist shared his reactions as a means to creating intimacy and helping the client see his own shame and reactions to it. The therapist also worked to stay present with the client by moving closer to him, making sustained eye contact, and monitoring and controlling his urge to deflect contact. The therapist also provided a holding presence for the client’s anger at having been unloved, as it erupted. These changes allowed the client to experience being known as safe, build a more unconditional self-esteem, resolve depression, and enter into more valuing contact with his wife.

Interview 10

The therapist had been through a difficult divorce and traced some of the difficulties of her husband to his mother, who was too narcissistic to offer him a relational foundation. The client was entitled and pretentious and reminded the therapist of her former mother-in-law. The therapist felt annoyed and initially had trouble empathizing with her client.

The therapist quickly noticed her annoyance and the similarity between the client and the therapist’s ex-mother-in-law. She thought about referring the client but decided she could and should take her on. A number of factors helped the therapist shift from annoyance to empathy:
Theoretical training re narcissism; consultation/ventilation with colleagues; prior understanding of and empathy for people in ex-husband’s family in terms of how they hurt each other and why, and emotional distance from her marriage and divorce; discussions with client’s children; exposure to client over time including a visit to her apartment when she was injured. The therapist experienced the client as an isolated person who deserved help in forming relationships, whose difficulties were determined by her own family history. The therapist was able to “step back from her own feelings of pain and observe” her client’s feelings. The therapist could express genuine empathy while educating the client about the effects of her behavior on her relationships.

The client was able to trust the therapist as a result of therapist’s empathy, own her unsuccessful interpersonal patterns, and actively seek and benefit from the therapist’s help in becoming more approachable.

As a result of this and other therapy relationships that have evoked personal reactions, the therapist’s “capacity for empathy increases and judgments of others seem to decrease” (personal communication, January 2004).

Interview 11

The therapist had lost a grandmother to suicide and the client looked like her grandmother and was also quite depressed. As a result of this resemblance and of the client’s dependence, the therapist felt a pull to rescue the client and at the same time doubted her ability to meet the client’s needs. At one point she expressed this doubt and the client felt rejected. At the same time the therapist grew attached to the client and lowered her boundaries more than
usual. The client was also lesbian and the therapist felt somewhat threatened by the client's erotic transference.

The therapist was accepting of her reactions and had the practice of asking herself in sessions what her reactions are about, therefore noticed both feelings of inadequacy and a pull to rescue the client. Beliefs that therapy is not all the client’s development but a piece of it and that answers lie within also helped the therapist not to be overly helpful or feel inadequate. The therapist also avoided the pull to rescue by not directly answering questions, by contesting the client’s idealization of her, and by having the client use psychology books as transitional objects. The therapist coped with inadequacy by reminding herself of her tendency to have inflated expectations of herself and of what good therapy requires, and also by mentally reviewing her client’s progress.

Using her own reactions as a guide, the therapist helped the client be aware of her dual neediness and need to be needed and how this affected relationships. The therapist was able to empower the client to look to herself for answers, make interpersonal needs known, and set limits on her own neediness.

**Interview 12**

The therapist came from a poor, relatively uneducated background and had both lingering concerns about fitting in with her professional peers. These concerns were shared by the client, and this connection led the therapist to avoid dealing with this area. Valuing autonomy but having seen her family and herself struggle work hard to survive, the therapist experienced ambivalence over a wish to be taken care of. At the same time the client was very strident in her complaints about her husband while being taken care of financially, and the therapist felt some
envy and judgment. The therapist had difficulty feeling or expressing empathy, expressed impatience at times. So long as she didn’t feel understood by the therapist, the client continued to complain without confronting her own behavior or expressing her real pain.

The therapist recognized her reactivity but let it go until she was doing couples work with a co-therapist and felt safer through the co-therapist’s presence to examine her reactivity and consult. Consultation with a group therapist later on also helped to sort through reactions, as did using a consultation group in which colleagues are open about personal issues. The therapist’s mutually accepting relationship with her husband and fact that her grown children were well-situated also provided this safety.

The therapist explored and understood the origins of her in similarity with the client’s family and socioeconomic background, and insecurities regarding belonging and being heard. The therapist was also exploring her family history at the time, helping her see parallels. She also let the client come to mind between sessions, making more connections. Hearing the client’s story and reflecting on parallels led to empathy, which allowed the therapist to contain and soothe her reactions, separate herself from the client, and be very immediate with the client. Also helping the therapist stay immediate were yoga breath practice and grounding self through physical sensations. Helping the therapist be empathetic were her many cross-cultural experiences and adaptations. Also the co-therapist helped by confronting the husband of the client and thus helping the therapist not to ally with him as an innocent victim of his wife’s dynamics. Being able to internalize others’ empathy for her led her to have empathy for her client.

Once her personal reactions were separated out the therapist could empathetically confront the client with her reactions to the client’s behavior. This combination of challenge and
support led the client to feel safe and explore her interpersonal reactions and alternatives. Facilitating all this were the client’s resilience and dedication to therapy, and thus adequate time in the therapy to work through and use the mutual reactivity.

The therapist found it useful to recognize again the effects of her history and increase her acceptance of her life and her choices.

The Grounded Theory: Process Steps and Connections

On the following pages are visual aids for understanding the grounded theory. Chapters V, VI, VII and VIII elaborate on the concepts and relationships outlined here.
Figure 3: Outline of Reactivity, its Management and Use

**Causes**

1) Therapist may have psychological wound(s) and/or needs rooted in interpersonal history.

2) Therapist may have interpersonal behavior developed to manage psychological wounds and/or needs.

3) Therapist may have psychological defenses developed to prevent awareness of psychological wounds.

4) Client has psychological wounds and/or needs rooted in interpersonal history.

5) Client has interpersonal behavior developed to manage cognitive-emotional reactions to psychological wounds/needs.

6) Client has psychological defenses developed to avoid cognitive-emotional reactions to psychological wounds.

7) Client’s behavior and/or resemblance to therapist or important person in therapist’s life may threaten therapist’s needs, increase therapist’s awareness of wounds, and/or activate therapist’s interpersonal tendencies.

**Reactions**

8) Therapist has cognitive-emotional reaction(s) to threat of unmet needs or awareness of psychological wounds.

9) If therapist is able to become aware of cognitive-emotional reactions, they might be managed without changing behavior toward client.

10) Therapist’s psychological defenses may prevent full awareness of reactions.

11) If therapist is unable to manage cognitive-emotional reactions internally, then therapist may act on them through reactive behavior toward client.

12) If therapist is able to act in a therapeutic manner while having to control cognitive-emotional reactions, therapist’s behavior may be incongruent.

**Effects of Reactions**

13) If 11 and/or 12, then therapist may threaten client’s needs, repeat wounding of client, and/or activate client’s psychological defenses and/or interpersonal tendencies.

14) Client’s psychological defenses and/or interpersonal tendencies may result in cognitive-emotional reactions demonstrated through reactive behavior.

15) If 14, then therapist’s needs, wounds, interpersonal tendencies and/or psychological defenses may be further activated, leading to a mutual reactivity cycle that repeats wounding from client’s interpersonal history.

16) If 14 or 15, therapy relationship and client development may be hindered and/or reach an impasse.
Figure 3: Outline of Reactivity, its Management and Use continued

Management Facilitators

17) Therapist has already established one or more of the following that facilitate management and use of reactivity:
   a) professional and/or personal relationships;
   b) self-care practices;
   c) self-awareness practices;
   d) therapist traits and attitudes related to their reactivity;
   e) theoretical/experiential training and/or theoretical concepts;
   f) prior understanding/transcendence of reactivity.

18) Client has one or more of the following that facilitate therapist’s awareness of reactivity:
   a) assertiveness in confronting therapist or acting out reactions;
   b) relationships that illuminate client reactivity;
   c) relationships that support client functioning and allow therapist to focus on reactivity.

Internal Management of Reactivity

19) Through management facilitators, therapist becomes aware of some aspect(s) of reactivity.

20) Therapist decides to manage reactivity based on commitment to client’s development.

21) Therapist explores reactivity through consultation, awareness practice, or contact with client’s social context.

22) Therapist reaches empathetic understanding of own reactivity and/or client reactivity and/or their interaction
   and/or their common roots in psychological wounds and/or needs.

23) Through empathetic understanding of self and/or client, therapist may contain cognitive-emotional reactions.

24) Through empathy and/or valuing contact with self, therapist may transcend cognitive-emotional reactions.

25) Through containing and/or transcending cognitive-emotional reactions, therapist is able to avoid psychological
   defenses or reactive behavior.

26) Therapist may continue to monitor self for cognitive-emotional reactions, psychological defenses, and
   interpersonal tendencies.
Figure 3: Outline of Reactivity, its Management and Use continued

Interpersonal Responsiveness/Use of Self

27) Therapist may share empathetic understanding of client’s reactivity.

28) Therapist may disclose own reactions to client’s reactive behavior.

29) Therapist may express congruent empathy for client.

30) Therapist may provide valuing contact to client.

Client Development*

31) If 27 and/or 28, client may develop an empathetic understanding of own reactivity.

32) If 29 and/or 30, client may have a corrective experience of relationship.

33) If 31 and/or 32, client may develop a greater capacity for valuing contact with self and others.

34) If 33, then client’s cognitive-emotional symptoms, daily functioning, and/or relationships may improve.

Therapist Development

35) Therapist may apply understanding and experience to future clients through greater alertness to and capacity for responding to reactivity.

36) Therapist may develop a greater capacity for valuing contact with self and others, and/or acceptance of life.

*Therapeutic factors such as the overall strength of the working alliance, the client’s external social support, client motivation, and therapeutic interventions that are not directly involved with therapist reactivity management contribute to client development as well.
Major Claims of the Grounded Theory

The following twenty-three statements are assertions based on the twelve therapists’ reported experiences; together these statements comprise most of the related ideas central to the grounded theory. Each of these statements is explored in depth and illustrated with evidence from the transcripts, in Chapters V through VIII.

1. Therapists’ reactivity tends to be of four types, none mutually exclusive: gratifying in response to dependency; avoidant in response to avoidance or aggression; aggressive in response to avoidance or aggression; incongruent in response to their effort to mask reactions.

2. Clients’ reactivity tends to be of three types, none mutually exclusive: dependent, in response to past/current abandonment or loss; avoidant, in response to past/current violation or abandonment; and aggressive, in response to past/current violation or abandonment.

3. Therapists’ reactivity is often interpreted by clients as further abandonment or violation, and reacted to in ways that therapists respond to with further reactivity.

4. Therapists who manage their reactivity successfully are sometimes facilitated in doing so by personal attitudes, traits, and theoretical beliefs that allow them to accept and explore their reactivity.

5. Therapists who manage their reactivity successfully are sometimes facilitated in doing so by professional and/or personal relationships that help them reach empathetic understanding of themselves and their clients.

6. Therapists who manage their reactivity successfully are sometimes facilitated in doing so by self-awareness practices and prior work on the personal causes of their reactivity.

7. Therapists who manage their reactivity successfully undergo a process of exploration to reach an empathetic understanding of their reactivity, their clients’ reactivity, and the interaction between the two.

8. An empathetic understanding of reactivity is based on identification of human needs that are being threatened, and sometimes includes the interpersonal history of those needs.

9. Empathetic understanding of self and client helps therapists to avoid acting out reactions to client reactivity.
10. Therapists’ empathetic understanding of themselves and of their clients may help them to either transcend or control reactions, or both.

11. Empathy for self may help to increase empathy for others and vice versa.

12. Self-valuing and empathetic understanding of their own reactivity allow therapists to understand and value their clients rather than be judgmental.

13. Therapists who manage their reactivity successfully vary between two approaches: the wounded healer and the relational expert.

14. Wounded healers use their vulnerability to reactivity in order to connect with clients and help them accept themselves and be in contact with others.

15. Relational experts contain or transcend their reactivity in order to connect with clients and help them learn to handle interpersonal situations differently.

16. Both wounded healers and relational experts usually need to monitor and control their reactivity once they have understood it.

17. Both wounded healers and relational experts may share their cognitive-emotional reactions to clients once the contribution of therapists’ own interpersonal needs is understood and set aside.

18. Therapists’ empathy for self and client helps clients who have experienced a lack of acceptance to attain a corrective experience of relationship.

19. Therapists who provide valuing contact when they disclose reactions they have to their clients, while also demonstrating empathetic understanding, help these clients to make valuing contact with themselves and others.

20. Clients who have a corrective experience through their therapists’ empathy, valuing contact, and/or empathetic understanding may gain the ability to offer themselves the same.

21. Clients who have a corrective experience through their therapists’ empathy and/or, valuing contact may gain in their ability to offer and experience valuing contact in other relationships.

22. Clients who gain in their ability to offer and experience valuing contact may experience reduced cognitive and emotional symptoms and/or improved daily functioning.

23. Therapists who manage their reactivity successfully may develop a greater capacity for valuing contact with self and others, as well as greater acceptance of life.
Narrative Synthesis

The core narrative tells the story of reactivity management that all twelve therapists have in common, taking differences into account. This story is told by the flowchart as well, and looking back and forth between visual and verbal representations of the core narrative may help the reader to grasp the process more easily.

The process of therapist reactivity management begins with an interaction between client and therapist – either actual, or anticipated through the therapist’s awareness – that may not be conducive to therapy goals if it occurs or continues unchecked. This reactivity is grounded in the interaction between therapists’ and clients’ psychological needs, interpersonal tendencies, and/or psychological defenses as they are expressed in the therapy relationship. In both therapists and clients the needs and sometimes the interpersonal tendencies and psychological defenses, are rooted in their interpersonal history, especially any psychological wounds. Similarities between clients and therapists, or between clients and significant persons in therapists’ lives, may also evoke psychological needs or wounds in the therapist related to whatever relationship pattern or aspect of self is evoked.

Therapists may become aware of their reactivity at several different points: cognitive-emotional or visceral reactions to clients; perceived similarity between clients and themselves or important people in their own lives; their own behavior toward clients; or their clients’ reactions to them. Depending on how and when therapists become aware of their reactivity, they may or may not be able to avoid expressing it behaviorally. If expressed, therapist reactivity may lead to patterns of interaction that recapitulate clients’ interpersonal history and continued self-defeating interpersonal functioning outside the therapy context, or impede the client’s progress toward
therapy goals in some other way, such as avoidance of important topics or prevention of increased client autonomy.

Therapist reactivity may be expressed in the therapy relationship in two ways. Either therapists seek to meet their psychological needs in ways that invalidate their clients’ strengths or suffering, or, in seeking to control their reactivity and be validating, therapists become incongruent in responding to their clients. In other words, the therapist’s therapeutic intentions are in conflict with their internal, cognitive-emotional reactions such that both influence the process. Clients generally do not experience themselves as cared for, understood, or connected with when therapists act out their reactivity or get caught up in trying to control it. At times however therapists may meet their clients’ dependency needs, while both may ignore needs for individuation or autonomy.

Therapist reactivity may provoke a constructive confrontation with the client. Anger motivated by the desire for a validating relationship can help clients confront therapists when their reactivity leads them to be invalidating.

Therapists’ awareness of their reactivity may be facilitated by several variables beyond client assertiveness. Prior awareness resulting from personal therapy, consultation, or reflection can be useful. Beliefs in the normality of being reactive to clients and the potential usefulness of reactivity for understanding and connecting with the client, are also helpful in permitting therapists to acknowledge their reactivity without threatening their self-concepts as effective therapists. A further extension of these beliefs, awareness/acceptance/_expression of one’s own emotional vulnerability as an essential therapeutic stance (here named “the wounded healer”) is also helpful in becoming aware of reactivity. A third variable in facilitating awareness of
reactivity is some regular practice of self-observation, either during or outside of therapy sessions.

Following awareness that something non-therapeutic is or has the potential for happening, therapists must make a decision about whether to manage this reactivity, to devote some attention and energy to it. Once the reactivity is noticed, therapists’ commitment to helping their clients becomes activated and helps therapists control, transcend, or meet their own psychological needs.

Typically, the next step after deciding to manage reactivity is to explore it with the goal of understanding. Again, the facilitating factors described above are helpful in this goal. Also helpful are established professional and personal relationships that provide acceptance and/or guidance for exploration and understanding. Therapists’ traits, such as personality and cognitive style, and theoretical education may also be helpful.

Sometimes understanding is enough; the reactivity is calmed and the therapist can be therapeutic without meeting the psychological need that was activated. “Containing” the reactivity by being aware of it, understanding its origins, and accepting its reality is often enough. In some cases further self-monitoring is needed to prevent the need from intruding into behavior. In some cases empathy for themselves in their pain at not having received empathy allows therapists to transcend the pain. This transcendence allows therapists to offer the same empathy to the client, especially when the pain is similar in origin. At other times empathy for their clients allows therapists to transcend their concern with their own needs, or meet these needs by opening up to the connectedness possible in the therapy relationship.

Therapists may range from acting in the role of relational expert, to being wounded healers who demonstrate or reveal their human limitations and/or suffering as a means of
connecting with clients. Empathic understanding in these cases encompasses both therapist and client, with the effect of helping clients to trust their therapists as real people who know what suffering is, yet also show that relief is possible.

In some cases, self-care activities such as rest, reading, exercise, yoga, and timing of therapy appointments help therapists to be present with clients rather than being distracted by unmet needs. In some cases, acceptance of the limitations imposed by human imperfection and life choices frees therapists from reactivity based on a lack of such acceptance.

In a number of cases, therapists share with clients some aspects of their understanding of their own reactivity. This can serve several purposes. First, therapists can help clients understand and manage their own reactivity by sharing how it affects the therapists as human beings. Second, therapists can provide a corrective experience as a person who is not perfectly empathetic or gratifying but still cares. Third, therapists by sharing their own reactivity can reach clients who feel completely isolated and unsafe in their own reactivity. None of the therapists found it necessary to share the specific origins of their reactivity in their own interpersonal history.

In combination with therapists’ repertoire of interventions, their efforts to manage their reactivity result in therapeutic experiences for their clients. Clients may avoid further escalation of self-defeating interactions, increase their capacity for contact in relationships, understand their reactivity better, experience reductions in presenting symptoms, and function better in life tasks.

As possibilities for self-relating and other-relating that are emotionally charged are opened up that do not prove catastrophic inside and outside of therapy, the client’s associated anxiety and/or depression tends to decrease. The capacity for making and accepting decisions
regarding needs, relationships, and life choices tends to expand as fear or hopelessness is reduced, such that overall functioning is enhanced and therapy is no longer needed.

Therapists may grow personally and/or professionally as a result of this process of understanding, managing and using their reactivity. In some cases the same pattern of reactivity can be anticipated and managed more easily with other clients. Some therapists change their whole approach to clients, becoming more deeply empathetic by being aware of both clients and themselves. Some therapists change their evaluation of themselves, becoming more tolerant of their limits or more confident in their resources. Some therapists reach a greater degree of acceptance of past difficulties or of past choices leading to present circumstances.
Figure 4: Overview of therapist reactivity, its management and use
Figure 5: Reactivity of therapist and client

Therapist interpersonal history

Therapist psychological wounds and/or needs

Therapist interpersonal tendencies and/or psychological defenses

Management of reactivity may prevent reactive behavior

Client resemblance to therapist or significant person in therapist’s life

Client reactive behavior

Client psychological wounds and/or needs

Client interpersonal tendencies and/or psychological defenses

Therapist reactive behavior

Therapist cognitive-emotional reaction(s)

Client cognitive-emotional reaction(s)
Figure 6: Management Facilitators and Internal Management of Reactivity

- (Mutual) Reactivity (Fig. 5)
  - Client Confronts Therapist
  - Self-Awareness Practices
  - Prior Work on Reactivity
- Therapist Awareness of Reaction
  - Decision to Manage Reactivity
- Exploration of Reactivity
  - Empathetic understanding of self
  - Shared woundedness
  - Empathetic understanding of client
  - Self-care practices
- Transcend reactions, defenses, tendencies
  - Contain reactions, defenses, tendencies
- Use of Self
  - Responsiveness
- Therapist Traits and Attitudes Related to Reactivity
  - Training and Theoretical Concepts
  - Supportive Relationships
  - Monitor reactions, defenses, tendencies
  - Self-Awareness Practices
  - Shared woundedness
  - Empathetic understanding of client
- Empathetic, valuing contact with self
  - Transcend reactions, defenses, tendencies
  - Contain reactions, defenses, tendencies
Figure 7: Responsiveness/use of self/client development

Responsiveness
- Explore threatening material
- Share empathetic understanding of client reactivity

Use of Self
- Disclose woundedness, vulnerability
- Express congruent empathy

- Disclose reactions to client’s reactive behavior
- Provide valuing contact

Client empathetic understanding of own reactivity
- Client corrective experience of relationship

Client capacity for making valuing contact with self
- Improved daily functioning

Client capacity for making valuing contact with others
- Improved interpersonal relationships

- Reduced cognitive-emotional symptoms
Chapter V
THERAPIST REACTIVITY, CAUSES AND EFFECTS

Introduction

This chapter will flesh out themes and variations in therapist reactivity, its causes, and its effects on the client and the therapy relationship. Therapist reactivity is defined as:

The activation of a therapist’s unmet psychological needs and/or wounds, rooted in the therapist’s interpersonal history and psychological functioning, expressed through cognitive-emotional and sometimes behavioral reactions within the therapy relationship, and activated by the client’s characteristics and/or behavior.

Mutual reactivity is defined as:

A cyclical interaction between therapist and client, in which their behavior activates each other’s psychological needs and/or wounds in a mutually escalating manner.

For reference, a flowchart of the reactivity process is available in the previous chapter (Figure 5, p. 123). A table (Figure 8) showing the basic content of therapist and client reactivity and its causes is presented on page 146. First some comments on terminology are offered. The word “causes,” though fortunate in its brevity, may convey a deterministic meaning that minimizes the active role of the therapist in mediating the process of reactivity. Labeling contributing influences “causes” can give the impression that the therapist is a passive conduit between contributing factors and reactions. If this were so there would be no rationale for this study.

While therapist reactions may be predictable, they are still mediated by individual frameworks of meaning. For example, the family therapist who had taught himself to be under-reactive had learned to value under-reaction as a sign of self-control and professionalism. Another person might have prided himself on his cultural heritage of emotional expressiveness,
and used it therapeutically. The question here is how different therapists, with their interpersonal histories and contexts, determined what their needs were and how they would respond when those needs were threatened by their clients. Therefore the word “causes” should be read as shorthand for “contributing influences.” In a similar manner, the word “effects” may appear to underestimate the mediating roles of both therapist and client on the potential impact of the therapist’s reactivity.

This chapter is organized by considering causes of reactivity first: origins in the therapist, client contributions, and dynamic interactions between the two. It should be noted that within these dimensions lie contextual factors such as racism and socioeconomic forces: not all causes are limited to the individual or family history. Therapists’ cognitive-emotional and behavioral reactions to clients and therapy events are considered next, followed by description of effects of these reactions on the client and the therapy relationship.

The key ideas of the grounded theory relevant to reactivity are:

1. Therapists’ reactivity tends to be of four types, none mutually exclusive: gratifying in response to dependency; avoidant in response to avoidance or aggression; aggressive in response to avoidance or aggression; incongruent in response to their effort to mask reactions.

2. Clients’ reactivity tends to be of three types, none mutually exclusive: dependent, in response to past/current abandonment or loss; avoidant, in response to past/current violation or abandonment; and aggressive, in response to past/current violation or abandonment.

3. Therapists’ reactivity is often interpreted by clients as further abandonment or violation, and reacted to in ways that therapists respond to with further reactivity.

Causes of Reactivity: Therapist Needs and Patterns

First, therapist needs and patterns of reactivity, defined explicitly or implied in the reactions, will be examined for common themes. Four themes appear to emerge from the data:
Self-concept maintenance, unfinished business, therapeutic caution, and avoidance of unpleasant emotions.

**Self-Concept Maintenance**

The most frequent common denominator in therapist reactivity appears to be the wish to be viewed and/or view one’s self in a favorable light, professionally and/or personally (Therapists 3, 4, 5, 6, 7, 9, 11). This need is at times intermingled with the need to be professionally effective, and may be difficult to distinguish from the need to be viewed or view one’s self as effective. This ambiguity seems to reflect the inherent ambiguity of all altruism, which naturally has at least some function of self-enhancement or self-preservation.

What does seem clear is the influence of clients’ behavior in challenging therapists’ self-concepts. Therapist 3 wanted to have confidence in herself as a therapist but was unnerved first by the client’s silence, then by her rage. Therapist 4, the family therapist, wanted to be seen as calm under attack, and defined this characteristic as a key ingredient of professionalism and a quality that distinguished him among therapists; however, the mother and stepfather of the identified patient were so vituperative and responded so explosively to the therapist’s calm demeanor that he had to re-evaluate himself. Therapist 5 wanted to see himself, and be seen by his client, as someone who did not make therapeutic blunders, who was always attentive and never “dropped the ball,” yet did so and was challenged to examine this self-image in light of the client’s clearly expressed hurt and anger. Therapist 6 wanted to see herself as effective at helping her clients reach goals efficiently, and needed to recalibrate her expectations in working with a client who required a very gradual and gentle approach. Therapist 7 wanted to see herself as having control over her life and as not being so emotionally wounded that it was hypocritical of
her to help others. Her client’s need to be joined with by someone who knew what it was to be wounded challenged this therapist to let go of illusory ideals of wellness and control. Therapist 9 found it tempting to be seen as, and see himself as, a font of wisdom. He acknowledged this grandiosity as an escape from the shame of being imperfect. His client provoked and challenged his grandiosity first by idealizing him, then by criticizing him. Therapist 11 wanted to see herself as a competent helper who can fix things and make everything better, yet her client could never seem to get enough answers.

It might be illuminating to reflect at this point that all of these therapists had at least five years of clinical experience following licensure, and most had many more years. All were nominated by several peers as highly competent therapists. Yet half explicitly traced reactions to clients to concerns about themselves as therapists.

One might react to this knowledge in several ways. For me as a relatively inexperienced therapist, it was liberating to know that therapists at all levels of experience and expertise could still be affected by self-doubt or by limiting definitions of “the good therapist.” Often it is the challenging client (in either sense, as one whose problems present a therapeutic challenge, or as one who verbally challenges the therapist) who provokes our dormant schemas about being good enough. These schemas can sleep so long as they are not challenged, so long as our effectiveness meets our expectations.

One might also reflect on the ambiguity of the therapeutic enterprise. One would be hard pressed to identify a more complex or ambiguous process than an extended, intermittent conversation whose goal is the emotional relief and growth of at least one of the participants. This ambiguity could be amplified by client resistance. For Therapists 3 and 7, their clients’ dissociative silence left only very subtle indications of whether this conversation was being helpful. Therapist 3: “So
I had to find ways to both move in and invite or offer her my presence without invading. And since she wasn’t able to talk about what was going on, that was real hard to do.”

Growth may be measured out in teaspoons, as with Client 6. Therapist and client may have to reach an impasse together before they can identify the problem as it manifests in the therapy relationship, as with Clients 4 and 7. Clients may be directly challenging, e.g. Clients 5 and 9. Clients may send conflicting messages regarding the therapist’s helpfulness, as with Client 11: the therapist was idealized, but no amount of help seemed to suffice. It seems that therapists may depend more than they know on their clients to offer direct or indirect feedback on their helpfulness. Therefore when such feedback is lacking, negative, or contradictory, there is plenty of room for self-doubt to be activated: “She didn’t choose to connect at the end of every session and say, ‘Oh, we did good work today.’ She would leave me hanging” (Therapist 3).

A third possible implication of the continued vulnerability of competent therapists to concerns about their ability is based on the intersubjective model of psychotherapy championed by object relations theorists (see Chapter II). This model assumes that both therapist and client come to the therapy relationship with psychological needs. The presence of therapist interpersonal needs in the intersubjective field of therapy is not necessarily an indication, as Freud asserted, of an incomplete therapist analysis or an improper countertransference. By and large, the needs the therapist is meeting are symbiotic with the client’s therapy goals, because one of these needs is to be helpful to others in achieving their developmental goals (Bacal & Thomson, 1996). Experienced, competent therapists may rarely be conscious of their need to be helpful or see themselves as helpful, because they usually are. However, when clients are deeply ambivalent about interpersonal contact and express this ambivalence in challenging ways, therapists’ dormant fears about being incompetent or unhelpful may surface.
Resolving Unfinished Business

Another, less frequent cause of reactivity identified by therapists (1, 2, 8, 11, 12) was an unmet interpersonal need that continued to be psychologically active either because meeting it was a continued source of gratification, or because its incompleteness was a source of suffering. Again, one sees the combination of a dormant need and a client who awakened this need.

For Therapist 1, feeling invisible to her depressed mother was a continued source of a need to be seen and understood. Her experience of feeling obliterated by the client’s inability to perceive her, except as a frustrating or gratifying source of attention, activated this need that the therapist had believed to be largely resolved. For Therapist 2, being a father to a young adult daughter was a great source of competency and comfort. Extending this to a young adult female client who was clearly asking would have been a natural continuation of a rewarding role. For Therapist 8, if his need to connect with his prim and proper mother had felt less resolved, he would have wanted to vicariously shock her by talking about sexual material with his prim and proper client. Knowing that her grandmother had succumbed to severe depression and committed suicide left Therapist 11 with a desire to vicariously rewrite the past by rescuing a depressed client who looked strikingly like her grandmother. For Therapist 12, coming from several generations of material deprivation yet valuing her autonomy left her feeling envious and frustrated toward a client who, materially, was well taken care of and not at all grateful for it. Thus the therapist’s need to have it both ways, to feel safe and to be independent, was stirred up by the client.

A comparison of these two needs, self-concept maintenance and resolution of unfinished business, demonstrates that therapist reactivity can draw from sources in the past, present, and
future. The past is only relevant as it continues to be felt in present interpersonal and intrapersonal interactions, whether as unfinished business that is repeated until a satisfying ending can be found, or as a continuous need for maintenance against threats to an existing arrangement for meeting needs. For example, one could trace the need to be helpful back to its family constellation for each therapist, but this need also seems to require ongoing fulfillment, rather than being an unmet need that goes away once resolved.

The need for such reinforcement of self-concept may seem pathological or a potential source of continuous interference in the practice of therapy; attachment to continual reinforcement could indeed be destructive. However, the intensity of the threatening stimulus (clients’ behavior) seems sufficient to help explain therapist reactivity here, in that these clients seemed more challenging of the “good therapist” schema than most clients tend to be.

**Therapeutic Caution**

Some reactivity can be accounted for by the desire to do no harm. Therapists 2, 3, 5 and 7 appeared to initially distrust how their clients would respond to confrontation with the therapist’s limits or presence. Therapist 2: “I was sensitive to the fact that she needed therapy, but she also needed the kind of structure of having kind of a father figure in her life…. I didn’t choose early on to kind of set that structure in place as I thought it would be somehow injurious to her to introduce that line of demarcation too early in treatment.”

Fear of damaging the client is not necessarily rooted in some self-concept need or unfinished business, it may simply be caution carried too far. Therapist 3 seems to have erred on the side of caution until the client let her know this felt like abandonment. Perhaps this is not reactivity per se, but a lack of clinical experience to draw from in a novel and challenging
situation. It is also possible (comparing this case to that of Therapist 7) that the therapist’s clinical imagination may have been blocked by fear that the client was or could become enraged.

This speculation highlights the fact that therapists can only address or later discuss reactivity of which they are conscious. Although the therapy impasse was resolved, one can never know if it could have been resolved more quickly if Therapist 3 had been aware of the client’s intense anger behind the dissociation. Another possibility is that strong reactions, like fear of hurting the client, can be grounded entirely in therapeutic intentions and sensitivity, and go completely astray without any interference from psychological needs or wounds. Furthermore, even if there were a way to get rid of all reactivity and only be responsive, one would still depend on the client to be responsive as well.

**Avoiding Uncomfortable Emotions**

Therapists 1, 3, 4, 6, 7, 9, 10, 11, and 12 were all motivated to avoid uncomfortable emotions (see Figure 8, p. 146) that were evoked by interactions with clients, their own unmet needs or unfinished business, and/or perceived similarities between clients and themselves or others. Therapists 1, 3, 6, 7, 10, and 12 all experienced some negative feelings toward their clients: “short-tempered” (1); “pissed off” (3); “frustration…impatience…anger” (6); “revulsion… impatience” (7); “irritated” (8); “annoyed” (10); “frustrated, resigned” (12). Therapists 4, 7 and 9 experienced shame and/or defensiveness: “What kind of role model am I…How much do I let her see me?” (7); “Outside I’m relaxed and inside I’m not” (4).

Therapists 1, 3, 7 and 11 experienced variants of being overwhelmed: “powerlessness” (1, 7); “primal fear with me about that sort of anger” (3); “how can I possibly fill that need” (11).
All of these therapists sought to avoid their feelings, usually through behavior toward clients: “going into grandiosity, to other ruses” (Therapist 9). Such defensive reactions represent an extra layer of reactivity that must be addressed, as well as the emotion that has been avoided in the first place.

Client Contributions to Therapist Reactivity

Although sources of reactivity in therapists have been discussed in light of triggering behaviors or traits in client, the focus now shifts to client contributions so that themes and variations can be identified. Two subcategories are discussed: client approach to interpersonal contact, and client similarity to therapist or significant person in therapist’s life.

Client Approach to Interpersonal Contact

The clients in all twelve therapy relationships sought validation or avoided invalidation (or other violations of psychological safety) in ways that tended to threaten or gratify therapist’s psychological needs. Clients’ interpersonal behaviors can be grouped according to the interpersonal stances of dependence, avoidance, and aggression. Some clients exhibited different stances in different stages of the relationship.

Clients 2, 9 and 11 (Client 9 was also aggressive later in the therapy relationship) may be seen as having approached their therapists with dependency needs: Client 2 wanted the validation and guidance lost when her father died; Client 9 wanted an all-knowing parent to emulate; Client 11 wanted an ideal partner to provide answers to life’s dilemmas. For Therapists 2 and 9, their clients’ dependency validated their competence (as a father in the first case, and as a therapist in the second). These therapists were therefore motivated to continue meeting their
clients’ dependency needs: “In some ways that it was a heady experience, for a while it appealed to my own, I suppose, grandiosity to think that this person thought I walked on water and he wanted to write down all my words” (Therapist 9). By doing so Therapist 2 would have avoided having to hold back his parental tendencies with a client who required such careful titration of therapeutic detachment; Therapist 9 could have avoided shame or doubt by becoming the all-knowing therapist. For Therapist 11, the client’s approach was so idealizing that she felt uncomfortable, at risk of being inadequate – a familiar if usually dormant theme for her.

Therapists 3, 6, 7, and 8 (3 was also aggressive later in the relationship) experienced their clients as avoiding contact, in the cases of Clients 3 and 7 to the point of long silences. The common denominator for these clients seems to have been avoidance of the threat of invalidation or other psychological harm by evading emotional contact with the therapist and others. The typical therapist response to avoidance was to feel frustration and a desire to push for contact or progress: “Take some responsibility for yourself” (Therapist 7’s silent thought). However, at times these therapists withdrew from contact themselves in different ways: “Not even talking about sex…or what it’s like being in the room with her” (Therapist 8). Therapist 3 was more worried about intruding than about building contact; therefore she colluded in avoiding contact for a time: “I would say ‘Don’t go into this any further than you feel ready to’.” For all of these therapists, feeling helpful and connected seemed to be at issue, and resulted in both the tendency to push for contact and the opposite tendency to pull away.

The remaining therapists were challenged by client aggression. Therapist 1 experienced her client as attacking her when total access to her was denied, or when poorly modulated rage was not accepted with a congruent empathetic response. Therapist 3 summed up her experience of the client as being distilled in the client’s statement, “I want to rip your fucking face off.”
Therapist 4 felt attacked to a degree impervious to any reasoning response: “I can sit here and imagine vividly the mom standing up, cursing me out at the top of her lungs.” Therapist 5 was roundly criticized several times for failing to remember important points or their significance; this was perhaps an appropriate level of aggression, but was followed by a disproportionate reaction by the therapist (see next paragraph). Client 10 did not direct her aggression toward the therapist, who appeared to respond to her differently from others from the beginning (perhaps for the same reason that the therapist at first doubted taking the case: she knew her type). Initially the client’s style grated on the therapist due to its familiarity, and the therapist had to process her reaction before she could fully empathize. Similarly, Therapist 12 did not feel directly attacked, but her client’s aggressive approach to being heard by her husband made it difficult to empathize with her predicament: “Couldn’t even listen to him get out one or two sentences without contradicting, objecting, interrupting, and absolutely could not be stopped.”

For therapists faced with client aggression, each case was unique in that each therapist had a unique history regarding aggression. Therapist 1 felt paralyzed by her client’s rage, losing her cognitive flexibility and ability to be compassionate, because helpless rage was such a powerful force in her as the child of a severely depressed mother: “There is a level in this anger that can stop me in my tracks when it’s coming from another person.” Therapist 4 needed to see himself as calm under all circumstances, and therefore could not own or express his anger congruently. Therapist 5 saw himself as consistently attentive, and any criticism of or lapse in this capability caused him disproportionate shame and guilt; he could not initially confront the client’s unrealistic expectations of him. Therapist 10 had been on the receiving end of her mother-in-law’s demanding nature, and had learned to deal with it in ways that allowed her to be less reactive to her client. Therapist 12 found herself judging her well-to-do client’s aggressive
search for power in her marriage as entitlement, due to the therapist’s lack of acceptance of her own history of economic deprivation and lower social class. Overall, none of the therapists met with aggression could initially meet the client where the client was, although difficulty getting there varied a great deal. Therapist 1: “But my fight with it in the room was interesting -- in my own powerlessness I think was generating an immobility of anger. To figure out that that was the only thing coming to me to do about this -- I couldn’t think of things that you do with hostility.” Whether through approach, avoidance, or aggression, clients’ efforts to achieve psychological safety within the therapy relationship could have come at the expense of their development, if their therapists had responded or continued to respond in reactive ways.

**Client Similarity to Therapist or Significant Person**

Therapists 1, 2, 8, 9, 10, 11 and 12 recognized that the client’s physical characteristics and/or behavior reminded the therapists of themselves or someone else. This perceived similarity set the stage for therapists’ concordant or complementary identifications and activated unmet psychological needs. Cognitive-emotional reactions were then evoked that undermined, or threatened to undermine, the therapists’ responsiveness to their clients’ therapy needs. These evocations can be understood as clustering along the lines of the client approaches to interpersonal contact described above.

Therapist 1 identified with the client’s rage at feeling invisible: “…hostility, real rage and anger, and the unrecognized hurt that probably was under that for her as it was under that for me.” Although the therapist did not see herself as similar in personality organization, she did resonate with aspects of the client’s experience, such as a profound need for unconditional acceptance. This identification, combined with the client’s demanding behavior, pushed the
therapist toward a more detached approach, technical neutrality that could protect the therapist from the unsettling emotions the client provoked.

Therapist 2 noticed from the beginning that his client was the same age as his daughter and had just lost her father suddenly and in tragic circumstances. The therapist anticipated that the client would have a powerful transference to him and that he would in turn be pulled to fill the role of father. His own enjoyment of the father role and his pride in being a good father also pushed him in the direction of fulfilling the client’s need for restitution:

Some things you know you can do and other things you know continue to be challenging, so it would have been easy to gravitate towards that because a lot of those things, sort of characteristics, a lot of needs that she expressed and a lot of things I know have worked with my own daughter in forming that relationship could have or would have worked with her, so it would have been an easy overlay.

Therapist 8 noticed early in therapy that his client resembled his mother in her interpersonal demeanor: she was sexually repressed and emotionally closed off, while viewing herself as a martyr for others. These parallels evoked what the therapist described as an “old narrative”: in order to differentiate himself from his mother and free himself of the sense of obligation her martyrdom imposed, he had to engage in shock tactics. On the other hand, he also felt the pull to engage in the undifferentiated narrative of not challenging his mother’s outlook.

Therapist 9 saw parallels between the client’s experience and personality and his own. Each had narcissistic mothers who left them with basic doubts about their worth. Each was praised for intellectual prowess, such praise being a pale substitute for unconditional love. Each feared close, sustained contact with another human being because it created the possibility of being known more profoundly and then rejected as “bad.”

Therapist 10 observed idiosyncrasies of behavior and underlying personality traits common to her client and her former mother-in-law. They used big words incorrectly in an effort
to appear educated; they made demands in a haughty manner. This similarity called up the therapist’s pain over her divorce, which involved her husband’s difficulties with relationship partly originating in his upbringing with a narcissistic mother. This parallel, in combination with the client’s alienating characteristics, challenged the therapist’s ability to empathize.

Therapist 11 saw a powerful physical resemblance between her client and her grandmother, who had committed suicide when the therapist was a child. Her client also suffered from suicidal depression. The therapist even wondered if her client could be a reincarnation of her grandmother. This connection seemed to actually be helpful in that the therapist called her client on an intuitive nudge, and learned later that this contact had intervened in a suicide plan. At the same time the strong resemblance complicated the therapist’s efforts to find a therapeutic stance that was supportive but not dependency-inducing: “And I wondered if part of my pull to rescue her was tied back to that.”

Therapist 12 saw many parallels between herself and her client: lower socioeconomic background, not feeling secure in the current professional milieu, alcoholism in the family, the wish to be taken care of. These parallels pushed the therapist to identify with the client and resent her lack of appreciation for her current comfortable circumstances, which the therapist envied: “So I sort of wanted to say to her, ‘You have it incredibly good. Don’t you see what you have here?’” This identification combined with the client’s shrill efforts to be heard led the therapist to feel frustrated and have difficulty empathizing or conveying empathy.

In reviewing these seven dyads together, several themes emerge. First, there are two distinct types of similarity. When the client resembles someone important to the therapist, the interpersonal and/or cognitive-emotional reaction to that person is evoked; when the client resembles the therapist in some way, a cognitive-emotional reaction to the self is evoked, such as
shame, and a secondary defensive reaction of avoidance follows. Racker (1957) identified these as concordant and complementary identifications, respectively. Thus for Therapists 1, 7, 9 and 12, distancing reactions are triggered that protect the therapist from painful confrontation with unaccepted aspects of self. For Therapists 2, 8, 10 and 11, reactions are directed toward the client from the beginning, as potential or actual enactments.

In summary, there are a number of ways to understand interactions of therapist and client contributions to therapist or mutual reactivity: therapist psychological needs in reaction to client inability to meet those needs or similarity to someone (including the therapist) involved in having frustrated those needs; degree and type of contact client is seeking in interaction with therapists’ capacity for tolerating contact or its absence; type of client defense against contact (dependency, avoidance, or aggression) in interaction with therapist defenses. These perspectives help to illustrate both the variety of potential interactions, and common themes of therapist and client needs for human relationship, validation, and development. Ultimately these needs, in most cases and to some degree, motivated both therapist and client to find a way beyond reactivity. Next are considered the ways and degrees to which therapist reactivity was experienced subjectively and expressed in behavior.

Therapist Cognitive-Emotional and Behavioral Reactions

Therapists’ reactions to the confluence of their interpersonal histories and client behaviors could have several dimensions. Some of these dimensions were internal and covert – thoughts, feelings, somatic expressions of emotion – and others were external and covert – verbal and nonverbal behavior toward the client. Not all of the therapists saw themselves as acting out their reactivity when their psychological needs or patterns were activated. Therapists 2, 10 and
Therapists 6, 8, and 9 noticed reactions as they evolved and generally avoided getting stuck in reactivity cycles. In contrast, Therapists 1, 3, 4, 7 and 12 recognized themselves as having reached veritable impasses that required a change of approach if therapy was to be salvaged. Therapy dyad 5 had a unique narrative discussed below.

What client and therapist factors may have determined whether an impasse developed?

Clients 1, 3, 4, 7 and 12 all demonstrated overt or covert hostility. Although Clients 3 and 7 may seem to have been more avoidant than aggressive, the therapists noted their reactions of feeling frustrated and angry; Therapist 7 imagined that these feelings represented the client’s inner experience, and Therapist 3 came to find out that her client was containing explosive rage. Certainly the behavior of total silence could be seen as an attack on the therapist’s function and, to the extent the therapist is identified with her work, on the therapist. In any case these clients all appeared to reject a therapeutic alliance in an active way that left the therapists with no obvious way to join with them.

One way to join with such clients that may seem clear from a theoretical perspective is to empathize with the client’s anger (which Therapists 1, 3 and 12 eventually did). However this is not so easily achieved when one is the target for such anger, or when the client evokes anger. Some of these therapists also had complex histories with anger or rage, as discussed above.
Therapist reactions to their own aggression were also complex, in that an aggressive response is often not considered acceptable in a therapist: “Well I probably dealt less consciously, only because that’s less acceptable… to be pissed off at your client” (Therapist 3). Therapists 1, 4 and 12 were incongruent: their words were not in keeping with their nonverbal response or at least with an expected human response. Therapist 1: “I didn’t feel sorry. I was much more aware of, ‘How will I get this person to stop this so we can start therapy…how do we get her to stop that so we can do the work, because I don’t like being yelled at.” Therapist 4 was inhumanly patient and calm in the face of abusive tirades – a reaction formation. A reaction formation is a defense characterized by feeling and doing the opposite of what one initially feels and wants to do. Therapist 7 described how her client elicited aggression that was difficult to face because it felt abusive:

The victim in her pulled at, you know, blaming the victim, and that was tough to…not hear myself but feel myself doing that very same thing. That was her process that she was blamed for everything and…then abused, and everything was taken, not everything, but a lot was taken out on her and how powerfully she could project that onto me. And I could equally respond right back to that, you know in terms of blaming her.

In general, therapists found it difficult to work with client aggression because the natural response – to get angry back – was seen as counter-therapeutic, yet any other response was initially inauthentic.

In contrast to the aggression expressed and/or projected by Clients 1, 3, 4, 7 and 12, Clients 6, 8, 9 and 11 engaged in avoidant or dependent behavior, as perceived by the therapists. Client 9 did challenge the therapist to debates, but aggression was not his dominant approach. By not evoking therapist reactions that were defensive in nature, these clients avoided a mutual reactivity cycle that would further invalidate them and provoke greater aggression on their part.
Therapist responses to avoidance included both collusion in avoiding interpersonal threats, and an element of frustration that could be either acted on passive-aggressively or contained through a reaction formation. Therapist 3 seems to have exercised an exhausting level of tact and caution until the client demanded more challenge to her dissociation. Therapist 6 seems to have acted on her repulsion by not moving toward a more emotional level of connection, instead being relentlessly goal-focused: “I was pushing at him and he was pushing back I knew it wasn’t so good for him, but that was a difficult thing to kind of control.” Therapist 7 was similar to Therapist 3 in her caution, except that her respectfully patient silence became suffused with impatience, with a nonverbal power struggle. Therapist 8 entertained a fantasy of shocking the client although he never acted on it; perhaps allowing this fantasy into awareness gave him the option of transcending it.

The location of the reactivity in the process between Therapist 5 and his client was somewhat different: rather than leading to a potential or actual counter-therapeutic interaction, it resulted from one. The reactivity led to a therapeutic confrontation between therapist and client – in fact, therapeutic for both. Although this case was atypical, in some ways it underscores a common theme: reactivity could become useful in moving the therapy forward, including when it interfered in therapy. This theme will be amplified in Chapter VII.

Effects of Reactivity on Therapy Relationship and Client

When their therapists acted out their reactions (1, 3, 4, 5, 6, 7, 8, 9, 11, 12), clients responded in ways that were predictable from their interpersonal histories, unmet needs, and in some cases self-defeating patterns. In some cases these patterns interacted with complementary patterns in the therapist, to create a mutual reactivity cycle (see Figure 5, p.123).
Client 1 responded with anger to the therapist’s incongruence and lack of sensitivity to the sources of her rage: “Reflecting her anger, I think she’d had a lot of that from therapists and it increased her rage.” Client 3 displaced her rage toward her abandoning mother (who did nothing to stop apparently obvious sexual abuse) onto the therapist, who appeared to abandon her to dissociation rather than push for contact: “When I would say, ‘Don’t go into this any further than you feel ready to,’ that kind of thing, she would interpret that, always, as me saying ‘I don’t want to hear this. I’m not going to go there with you.’” The parents of Client 4 escalated in an effort to disturb the therapist’s preternatural calm: in the words of the stepmother, “But we felt that you still wouldn’t engage us, you wouldn’t connect.” Client 5 felt abandoned by the therapist and complained bitterly: “Somehow I don’t think you really know what this is to me”; this seemed to be a constructive rather than self-defeating response to a counter-therapeutic therapist behavior. Client 6 could not develop a greater capacity for relationship so long as the therapist did not feel moved to seek connection with him. Client 7 remained silent, waiting for the therapist to capture her nonverbal experience before she would make contact. She also felt that the therapist might give up on her, and asked her not to. Client 8 kept to an emotionally distant problem-solving level, not recognizing distance as part of the problem, because Therapist 8 didn’t challenge her: “For a while [my reactions] led me to pretty much to stay on the surface and not focus on anything…focus more on sort of the anxiety component of what she came for, rather than dealing with the sort of relational piece. Or the emotional piece.” Client 9 kept avoiding real contact so long as his therapist would give in to the desire to “leave the contact and the immediacy of the experience and to run away basically. To put again a barrier in between us.” Client 11 felt abandoned when the therapist expressed her misgivings about being able to do enough for her; she also blurred boundaries when the therapist didn’t guard them carefully.
Client 12 crowded out any response with a monologue so long as the therapist wasn’t empathetic enough to listen through the barrage to her client’s need for validation: “I think she needed a lot more safety in her therapy. She sensed that she wasn’t really safe in therapy.”

When confronted with therapists who did not meet their relational needs, the majority of the clients acted on their unmet relational needs in familiar ways, even though in other ways most of them wished to grow past these patterns. However, in all but one case (the parents of Client 4 seem to have been too wedded to viewing their son as the problem), therapists and clients were able to see these patterns in action and practice new ways of interacting that were more rewarding. In Chapter VI, therapist, client, and contextual factors facilitating this awareness and change will be examined.
Figure 8: Therapist and client reactivity and its causes

<table>
<thead>
<tr>
<th>Ther. #</th>
<th>Therapist Psychological Need</th>
<th>Therapist Emotional Reaction</th>
<th>Therapist Behavioral Reaction</th>
<th>Client Behavioral Reaction</th>
<th>Client Emotional Reaction</th>
<th>Client Psychological Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Resolve anger at feeling invisible</td>
<td>Powerless-hurt-threatened</td>
<td>Immobilization/incongruence</td>
<td>Rage/demand/avoid</td>
<td>Enraged-depressed-hurt</td>
<td>Receive acceptance/avoid abandonment</td>
</tr>
<tr>
<td>2</td>
<td>Relieve distress, be fatherly</td>
<td>Moved-pulled</td>
<td>Act as father vs. therapist</td>
<td>Express needs</td>
<td>Anguished-needy</td>
<td>Have a transitional father figure</td>
</tr>
<tr>
<td>3</td>
<td>Not intrude and retraumatize</td>
<td>Tentative-scared</td>
<td>Be too cautious</td>
<td>Dissociation/raging</td>
<td>Terrified-hurt-enraged</td>
<td>Give voice to hurt/avoid hurt</td>
</tr>
<tr>
<td>4</td>
<td>Not come across as reactive</td>
<td>Defensive-angry-threatened</td>
<td>Incongruence (angry w/ calm exterior)</td>
<td>Bullying-threatening</td>
<td>Righteously angry</td>
<td>Be met with equal passion</td>
</tr>
<tr>
<td>5</td>
<td>Maintain image of impeccability</td>
<td>Guilty</td>
<td>Criticize self/ catastrophize</td>
<td>Express indignation/dejection</td>
<td>Hurt</td>
<td>Not be emotionally abandoned</td>
</tr>
<tr>
<td>6</td>
<td>Feel effective and connected</td>
<td>Repulsed-frustrated</td>
<td>Lack empathy/push toward goals</td>
<td>Avoid contact/engage in blaming</td>
<td>Angry-disconnected</td>
<td>Be safely connected to</td>
</tr>
<tr>
<td>7</td>
<td>Avoid hurt/shame being wounded</td>
<td>Frustrated-deadened</td>
<td>Punishing silence</td>
<td>Dissociation/deadness</td>
<td>Dissociated-terrified-anger</td>
<td>Be seen without being hurt</td>
</tr>
<tr>
<td>8</td>
<td>Connect/avoid provoking</td>
<td>None given</td>
<td>Avoid intimate subjects</td>
<td>Avoid intimate subjects</td>
<td>Anxious</td>
<td>Avoid embarrassment</td>
</tr>
<tr>
<td>9</td>
<td>Avoid shame of intimacy</td>
<td>Ashamed-anxious-complacent</td>
<td>Deflect/pontificate</td>
<td>Idealize/challenge</td>
<td>Ashamed</td>
<td>Avoid shame of intimacy</td>
</tr>
<tr>
<td>10</td>
<td>Cope with loss of marriage</td>
<td>Annoyed</td>
<td>Lack empathy</td>
<td>Demanding-entitled-false erudition</td>
<td>Self-doubting</td>
<td>Be understood/not abandoned</td>
</tr>
<tr>
<td>11</td>
<td>Feel competent/rescue</td>
<td>Unsure of self/Attached to client</td>
<td>Express self-doubt/ loose boundaries</td>
<td>Idealize-seek merger</td>
<td>Overwhelmed-lonely</td>
<td>Feel guided and loved</td>
</tr>
<tr>
<td>12</td>
<td>Feel competent/be taken care of</td>
<td>Frustrated-critical-envious</td>
<td>Lack empathy-be passive-avoid topics</td>
<td>Escalate-complain</td>
<td>Neglected-hurt</td>
<td>Be taken care of/be heard</td>
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Chapter VI

FACILITATORS OF THERAPIST REACTIVITY MANAGEMENT

I have started to get filled up with that [loving gaze] and see how valuable that is, and that is not a technique. I mean it is, but you can’t fake that. If it ain’t there you can’t let yourself sort of really look at somebody and feel love and genuineness; they are not going to experience it.

-- Therapist 7

Introduction

In those therapy relationships therapists perceive as successful, what factors conspire to assist therapists in managing their reactivity constructively? Conceptually it may be difficult to divide facilitators of reactivity management from the process of managing reactivity. For example, the availability of a consultation group facilitates management, whereas actually consulting with such a group is a step in the management process. A trait such as acceptance of one’s emotions may facilitate awareness of reactivity, and at the same time actively accepting a particular emotion is a management process. In terms of application of this grounded theory to practice, however, the distinction is easier: management facilitators are relationships, beliefs, personality traits, knowledge, and practices one can cultivate so that they are accessible when needed, or so that they provide a state of readiness to respond to reactivity; the process of reactivity management is applied to a particular therapy interaction or relationship. An additional set of facilitators lies outside therapists and their activities: client factors.

In this chapter I explore the question of how management facilitators aid the process of reactivity management, looking first at therapist traits, beliefs, attitudes, theoretical constructs, training, and prior work on psychological problems; next at professional and personal relationships; then at therapist self-care and awareness practices; and finally at how clients may
facilitate reactivity management through their behavior. Synergies among these facilitators are also described, and the place of management facilitators in the overall theory is discussed.

Key ideas of the study relevant to facilitators of reactivity management are:

1. Therapists who manage their reactivity successfully are sometimes facilitated in doing so by personal attitudes, traits, training, and theoretical beliefs that allow them to accept and explore their reactivity.

2. Therapists who manage their reactivity successfully are sometimes facilitated in doing so by professional and/or personal relationships that help them reach empathetic understanding of themselves and their clients.

3. Therapists who manage their reactivity successfully are sometimes facilitated in doing so by self-awareness practices and prior work on the personal causes of their reactivity.

Therapist Commitment to Managing Reactivity

Implicit in every aspect of their efforts to manage personal reactions is the professional commitment of the therapists to offer the client a therapeutic experience. This commitment may be seen as the expression of a psychological need, perhaps life purpose. This need may conflict with other psychological needs of the therapist noted in Chapter V, for example, avoidance of unpleasant emotions or self-concept maintenance. One may also conceive of therapeutic commitment as serving self-concept maintenance. In fact the therapist’s professional identity may be central enough that other identities – being the “good father” (Therapist 2), the “family hero” (Therapist 5), the unflappable one (Therapist 4), or the together person (Therapist 7) – can be successfully challenged in the process of discovering a way to be therapeutic.

On the other hand, one cannot take for granted that the commitment to be therapeutic will always trump other motivations. Therapist 7 described succumbing at times to the emotional deadness and sleepiness of the client’s dissociative state. Therapist 9 gave the example of becoming complacent and not working hard when the client avoids interpersonal contact.
Therapist 12 described letting sessions go by in which the client fills the time without really engaging in self-development. Ultimately, none of these therapists was willing to let therapy continue at that level. These examples point out the challenge of initiating a shift when the client is not pressing toward change.

The implicit commitment to offer the client a therapeutic experience was expressed by some therapists as a decision to take on their reactivity in order to be able to work effectively with their clients. A decision to engage with the client rather than referring her to another therapist is noted by two of the therapists (1, 10). These therapists were struck from the first session by similarities between their clients and significant figures in their lives. Yet the therapists decided to set aside their initial doubts and thereby take on whatever complexities would arise from these similarities. Another expression of therapeutic commitment is noted by Therapists 1, 4, 5, 7 and 12: to seek consultation based on the intensity of emotional reaction and lack of a way to manage it.

It is interesting to note that in no case did any of the therapists talk about this commitment directly, yet without it one can hardly imagine that efforts to manage reactivity would have occurred. Commitment is included in the theory because of its potential utility as a touchstone for therapists struggling with reactivity to a client. Readers may ask themselves, “To what lengths will I go to help my client? How much discomfort will I tolerate?” While perhaps rooted in therapists’ interpersonal histories, therapeutic commitment may also be generated by future-oriented striving -- for wholeness, relationship, individuation – and this striving is sometimes wholly on behalf of the client, sometimes for both therapist and client.
Therapist Traits and Attitudes

Two related subcategories that emerged from data within the Management Facilitators category are Therapist Traits and Attitudes. They are considered together here because of their close relationship to each other. An attitude that is consistently held and acted upon, such as acceptance of people as essentially good even when their behavior is destructive, may be viewed as a trait and vice versa.

Several therapists, when asked about personal qualities facilitating reactivity management, pointed to traits or attitudes related to awareness of or acceptance of reactivity. Therapist 1 stated, “I’m predisposed to go and work on those, want to keep my own reactions conscious…. ” Therapist 11 described a similar ability and inclination: “I’m pretty aware of my reactions I think. Pretty aware. Pretty quick.” The origin of such awareness was clear to Therapist 8: “Which is probably why I’m a psychologist anyway. Because that’s what I did. I grew up doing that. Because I wanted or needed to watch.”

In addition to a predilection for attending to reactions, a number of therapists expressed belief in the importance of doing so for therapy to be most effective. For example, Therapist 8 described “a theoretical sort of interest or orientation or belief that those sorts of reactions are essential to sort of understanding somebody else and if possible certainly going to be useful in terms of intervention.” Therapist 4 advocated for regular consultation as a way of cultivating such awareness: “…if you’re not consulting on your cases I don’t think you’re doing a good service to your client. Deal with your own emotional reactions to things.” Therapist 9 specified that even defensiveness can be put to use, by exposing its roots in the shame that therapist and client have in common, thus helping the client have the corrective experience of emotional intimacy, of being accepted warts and all.
Therapist 6 summed up her attitudes: “I think [personal reactions to clients]…are unavoidable, I think they are human and I think they are useful.” Therapist 7 explained how she finds reactions useful: “That’s for me what makes psychotherapy alive, because I can use myself in that way and use my emotional reactions to both develop intimacy and the closeness, and then to also use that relationship for them to check out previous assumptions about the world and try on new behaviors, new ways of being in the world.” These therapists seemed to focus largely on the objective side of reactivity, that which illuminates the client. However Therapists 6 and 7 also seemed to suggest the possibility that subjective reactivity, rooted more in the therapist’s unresolved issues or unmet needs, can also be therapeutic in strengthening what Gelso and Carter (1985, 1994) termed the “real relationship,” i.e., the relationship based not on transference of past situations, but on accurate experiences of each other in the present.

Another set of traits and attitudes has to do with use of self, empathy, and being a wounded healer. In some cases the attitude toward use of self involves setting aside personal concerns, as Therapist 7 expresses: “The trust that I now have is that I can be there. I really can put myself on the back burner and the engagement with the client in the therapeutic hour is pretty…like if somebody sits down and tells me what happened this week or where they are at I can say ‘I’m glad I am here.’” On the other hand, in some cases use of self involves tuning into client needs through one’s own unmet needs. Again, Therapist 7: “I think that part of my wounding has been that I am able to connect with people…when they haven’t felt held enough or touched enough.” Therapist 12 phrased it: “I think that paradoxically the very things that can make me reactive to these sorts of issues are some of the things that have made me empathic too.”
Other attitudes facilitating reactivity management address the power and importance of the relationship with the client. To Therapist 1, “the healing part, the relief part is in the experience of therapy.” This belief grew out of personal growth in therapy that required more than cognitive intervention. Therapist 6 addressed the humanity common to both therapist and client: “I feel really strongly that whenever you start dealing with someone as a them or an other instead of another human being who possesses any potential that you have, then I think that you start getting into all sorts of trouble.” These therapists were primed by their attitudes to pay attention to the experience of being with the client as another human being.

A further step in use of self and empathy is awareness of common psychological wounds, or in the terms of the grounded theory, common interpersonal history and unmet psychological needs. Therapist 7 identified the wounded healer construct in explaining her stance toward the sources of her own reactivity: “I think the most powerful concept for me is the notion of the wounded healer. …it isn’t about the wound necessarily sealing and healing over completely, but experiencing and knowing that it is there, and being aware…of your own wounding.” At the same time, being aware of the wound of not experiencing being deeply valued caused this therapist to seek healing through her own therapy: “I have started to get filled up with that [loving gaze] and see how valuable that is, and that is not a technique. I mean it is, but you can’t fake that. If it ain’t there you can’t let yourself sort of really look at somebody and feel love and genuineness; they are not going to experience it.” The dual awareness of both psychological wounds and healing seems to allow the therapist to provide both types of corrective experience: that which allows the client to feel known in his or her suffering, and that which allows the client to feel valued, to counteract the suffering of not feeling valued.
Some therapists (4, 6, 8) found that their tendency to not be reactive was helpful in coping with reactivity when it did emerge. Therapist 4, in spite of the fact that his struggle was to allow himself to react, still credited his “ability to remain calm” with helping him manage his reactivity. It seems that he needed both detachment and genuineness to express his frustration to his clients’ parents in a way they could hear. Therapist 6 noticed that her openness to examining her reactivity depended on being “pretty non-judgmental…I don’t tend to be too hard on myself and that is not to say that I don’t keep trying to make changes, but if I have done something that I am not real pleased with or if I had done something that I wish I could do differently I don’t stay there.” Therefore she did not feel the need to defend herself from knowing if she made a mistake.

Some attitudes about therapy can be helpful in anchoring one’s response when reactivity threatens to blow one off course. Therapist 1 noticed that contrary to her philosophy of seeing the client’s resistance as the arena in which therapy occurs, she was wanting to control her client’s anger to be able to move on to “the real therapy.” This observation helped her decide to consult. Therapist 11 used her attitudes about therapy to counterbalance her tendency to engage in rescuing behaviors: “I don’t think it’s in the client’s best interest to give the answers and, that’s just my philosophy about therapy, and so I would not do it.”

Therapist 8 described slowness to react as a temperamental quality or cognitive style: “I guess my quality is patience or maybe just being slow depending on how you want to define them….I guess that I tend to be not reactive and so I tend to sort of mull things over and just sort of, at my age I’ve begun to see it as a positive patience.” Thus it seems useful for therapists to take stock of their unique personalities in order to capitalize on existing traits in their efforts to manage reactivity.
Training and Theory

Some therapist attitudes about therapy and abilities to manage reactivity are developed in part through didactic and/or experiential training. This area may be of particular interest to therapists in training, clinical supervisors and educators, because it represents the contact point between theory and practice. If theory can have traction in the area of reactivity, where theoretical convictions could be overwhelmed by personal needs or used to rationalize acting out of reactivity, then it is important to know how this traction is achieved.

The small number of participating therapists, the fact that virtually all of them live in the same university town, and the fact that many are affiliated in some way with the same graduate programs and training groups, point to the strong possibility that there exist theoretical frameworks that could facilitate reactivity management but are not represented in this study. All but one of the therapists listed theoretical orientation(s); most listed more than one. In actuality, the therapists’ theoretical orientations varied more widely than their descriptions of their work would seem to imply. While their narratives focused a great deal on relationship dynamics – naturally given the topic – cognitive/cognitive-behavioral was the second most frequent designation (4 therapists), after eclectic or integrative (6). There may be several explanations for this apparent discrepancy. First, a cognitive-behavioral orientation by no means implies that one is disinterested in the therapy relationship. Rudd and Joiner (1997) demonstrated that even traditionally psychodynamic experiences like the transference-countertransference relationship can be described in cognitive terms.

Second, one may conceptualize the client’s problems and the therapy relationship in one theoretical language and work primarily in another. For example, one may think of a client’s abandonment issues as rooted in object relationships, but work to challenge the beliefs about
relationships that are being maintained by errors in thinking. A third explanation is that therapists are rarely purely anything. Therapist 5, who labeled himself “cognitive-behavioral,” noted in a follow-up communication that the concepts of corrective emotional experience and forgiveness are central to his work. Only four of the therapists gave only one theoretical orientation, and two of these were “eclectic.” Two of the therapists gave four different orientations.

The three next most frequent orientations were psychodynamic/psychoanalytic/object relations (3 therapists) and humanistic/existential (3); two of the latter also described themselves as gestalt. Feminist therapy and interpersonal therapy were also represented. These orientations fit more closely with the concepts and language used by most of the therapists. Certain concepts found their way into the grounded theory, which did not seem to be a problem so long as the therapist was keeping the conceptualization tied to concrete experience.

There was no clear relationship between theoretical orientation and the extent to which a therapist gravitated toward the wounded healer or the relational expert approach, for the same reasons as cognitive approaches did not exclude consideration of the therapy relationship. However, all of the humanistic, existential, and gestalt therapists (1, 3, 7 and 9) were in the wounded healer group. Unfortunately or not, the sample size is too small and sampled in too theoretical a way to be of any use in making generalizations.

Relationship-oriented theoretical frameworks share a metaphorical language for describing relationship events that appear to be central to transcending mutual reactivity. This language is predominantly physical or embodied. Therapists use words like wounding, healing, holding, seeing, being pulled, feeling pushed from within, being grounded, being balanced, feeling dead, feeling alive. It may be instructive that George Kelly, developer of a comprehensive constructivist theory of psychotherapy (1955), was careful to note that constructs
are not exclusively or even necessarily cognitive: they may be preverbal, lived rather than thought. Some of the clients the twelve participants chose to discuss may have been challenged by unmet psychological needs at preverbal ages and/or in nonverbal ways. Certainly Clients 1, 3, 6, 7, 9, and 12 were responsive to noncognitive aspects of the therapy relationship, such as valuing contact.

Training could be relevant as a starting place from which some therapists differentiated themselves in ways relevant to managing reactivity, often in the direction of focusing on relationship, emotion, and the body. Therapist 1:

I went to a very cognitive-oriented program and as I applied all that to myself it only worked so far. And in my own therapy, for me I realized it wasn’t enough…that I could do all the cognitive restructuring I wanted and that all that had value and all of that did help in terms of stopping my own critical voice and all those things -- not that I don’t think those techniques work, I think they’re wonderful. But I also think there can be a negative stance, that unless felt, recognized and switched on a deeper level won’t lead to characterological change. It will increase functioning in the world, but it will not transform inner deep anguish that people have.

This therapist found a home in “the existential-humanist and gestalt” frameworks. She described the “approach to reactions to feelings is to use them therapeutically. Part of what’s going on interactively in the therapeutic relationship is a strong indicator of what the work is.”

Therapist 7 also moved away from what she was taught, both through some of her own therapy experience, and through her clinical training:

…in many ways modeling…how I do therapy after what was healing…for me in my own therapy, and then also evaluating what I wanted more of and wasn’t getting from my therapist too….I think he was one person who could have done a lot more personal sharing to normalize my process… like I am really the only one that is fucked up here.

…finding aliveness in there [the therapy relationship], and letting myself be different than what I think other people may be doing you know in psychotherapy….because our training is very much you know a blank slate and the therapy that I do a lot with clients does involve touch.
Therapist 3 found a theoretical framework that suited her early on in her education, and stayed with it. She viewed herself as a gestalt therapist, using the concept of contact as an organizing principle and as a guide to practice: “Everything I do is about being aware of what’s happening in the contact, in the moment.” She also described how immersion in this framework through experiential training helped her develop confidence in taking risks, in allowing the present moment to unfold, in trusting the process of unfolding awareness. This confidence allowed her to tolerate the ambiguity of working with her highly dissociative client. By being tuned in to the quality of interpersonal contact, she was also able to notice her own reluctance to push for contact with her client.

Specific theoretical constructs gained through training were helpful to several other therapists. As a result of her participation in an object relations study group, Therapist 6 was able to apply Masterson’s work on the schizoid personality to viewing her client in a more empathetic light. Therapist 10 vividly described a moment in her graduate education that later helped her develop the empathy she felt for both her mother-in-law and her client who resembled her mother-in-law:

We were watching a videotape of somebody talking about a parent and he said, “You know, if this woman’s your client, then you really understand that, what her mother did to her and how her mother raised her, and how she turned out that way. But, if the mother’s your client, then you understand something else.”

As a result of this training experience, Therapist 10 developed the belief that “if you go back far enough, nobody’s ever at fault.”

Therapist 12 described how her empathetic understanding of her reactivity and her client’s were both grounded in the concept of differentiation from a book on marital therapy, A Passionate Marriage by David Scharff: “It’s about differentiating and about being able to manage
your emotions and take a stand.” Therapist 12 noticed that she was not well differentiated from her client when reactive to her, and that her client was not well differentiated from her husband.

It seems that in these three cases – Therapists 6, 10, and 12 – theoretical constructs facilitated empathy. This makes logical sense in that psychological theory is meant to facilitate a deeper understanding of behavior. Deeper understanding often taps into human motivations that we all share. Seemingly selfish or hurtful behaviors, like the victim stance of Client 6, the entitled attitude of Client 10, or the shrill complaints of Client 12, came to be understood by their therapists as protecting against the risks of intimacy or defending brittle self-esteem. Empathy is an understanding of common humanity, especially in its painful aspects. Perhaps one criterion for theory being helpful in transcending reactivity is whether it provides an empathetic account of therapist and client thoughts, feelings, and behaviors.

Prior Work on Reactivity

Another way in which reactivity can be diminished or harnessed is through prior personal therapy or other means of resolving unmet psychological needs. Seven of the therapists mentioned some previous personal growth that allowed them to be less reactive or more aware of their reactivity. In some cases the connection was vague – Therapist 3 referred to the therapeutic component of her gestalt training without spelling out how it helped her cope with her client’s dissociative silence or rage. Therapist 8 credited “years and years of being in treatment myself” with helping his issues with his mother feel “finished in my own body and soul in some way” so that he could more easily connect his reactions to his own history. Therapist 9 credited prior work on his issues parallel to those of the client with being able to trust his approach of pushing for contact:
I would say the greatest is, you know, for better or worse, I’ve done a lot of the work of the same journey that I was asking him to make, so I can trust the territory and trust the possibility of the outcome rather than it being just an abstraction or academic.

Therapist 12 indicated that in her marriage and the work she does “on herself,” the same issues of envy and inadequacy had been explored and resolved to a degree.

Some therapists were more specific in how prior resolution facilitated reactivity management. These processes had to do with empathic and/or valuing contact with clients. Therapist 7 described a connection between being valued and being able to value: “…that sort of gleam in your eye, that loving gaze…I think that that has been very powerful for me to receive from my therapist and from other people and then to be able to give back.”

Therapist 7 had participated in regular personal therapy that allowed her to confront and accept her own difficulties in feeling competent and healthy, and this acceptance contributed to her ability to tune into and accept the client’s experience as it was communicated through projective identification, i.e. nonverbal elicitation in the therapist of her own feelings. Thus the therapist’s therapist had ultimately offered her his acceptance of his own psychological wounds. Such valuing relationships seem capable of being transmitted from one therapy “generation” to the next, much as family dysfunction appears to be transferred: through identification with the other and modeling how one treats the next person after how one has been treated.

Therapist 9 identified working through an interpersonal defense as helpful: “I mean I’m a lot better at it [not deflecting intimate contact], I’ve certainly done a lot of my own work on it in therapy.” Therapist 10 saw understanding of people who had hurt her as helping her empathize with her client: “And so I just had processed a lot of that for myself over time, and not just after having been divorced, but many years of marriage, just sort of understanding why this happened,
was so dysfunctional and why people hurt each other the way they did.” Therapist 11 described a shift in beliefs underlying her feelings of inadequacy:

The rescuing and I would say the sense of never quite being adequate, or never feeling adequate… I mean that’s something that I worked on some all through my training, you know and I don’t feel it so much now and I don’t feel it with every client… what I have discovered about myself is that in most situations my expectations of what is actually needed to be good enough is like far beyond what’s needed to be good enough… and so nothing’s ever done is sort of what I’ve come to believe.

These examples of personal growth reflect the distinction between cognitive and experiential change that is also evident in how therapists described change in their clients. It is entirely possible that these do not represent different types of change, but different angles on similar phenomena. In fact, the distinction between cognitive change and experiential or feeling-level change should not be taken for granted. In order for experiences to be generalized beyond specific situations, they must be encoded in some way as examples, e.g. examples of relationship. At the same time, in order for such change to be effective, i.e. to overcome previously encoded experiences, then the new experience of relationship must be compelling. It must feel rewarding, safe, etc., and this feeling must be connected to some account of why the relationship is different from past relationships.

Although the emphasis on felt experience versus cognitive change may be a matter of perspective, it is also possible that therapists who emphasize cognitive change in their clients or themselves are pointing to an incomplete process, one that is logically but not emotionally compelling. This question is important to reactivity management: is a resolution of the therapist’s psychological needs on a “feeling level,” as Therapist 1 put it, essential to genuine empathy or valuing contact with clients? Or is monitoring for and challenging reactions based on irrational beliefs adequate? Perhaps different conditions determine which approach is necessary or sufficient, such as the emotional intensity of the therapist’s reaction, the centrality of the beliefs
being challenged, or the client’s degree of need for the therapist’s emotional presence. The data available from these twelve interviews cannot answer any of these questions, but readers who practice psychotherapy can certainly pose this question of themselves in their own work.

In any case, these examples argue for the relevance of therapists’ own therapy or other means of personal growth to their ability to manage their reactivity, in both global and specific ways. A number of therapists (1, 7, 9, 10, 11, 12) described management of unfinished business as an ongoing process. Therapist 12 also suggested that the work is ongoing: “And not that I’ve never worked on these issues before, but they continually recycle….” Thus there may be some danger in therapists assuming that a particular source of reactivity is resolved and requires no monitoring.

Professional and Personal Relationships

The preceding section illustrates that prior work on reactivity often occurred in the context of relationships. Therapists’ current relationships with others facilitated every aspect of reactivity management. Whether personal or professional, relationships provided a container for emotional reactions (4, 7, 10, 12), a place to explore reactivity, (1, 4, 7, 12), a source of understanding of the client (1, 4, 6, 7, 12), and/or a valuing relationship that could be internalized and then offered to the client (1, 7, 12).

Relationships with colleagues and therapists of their own sometimes appeared to help therapists accept and ventilate the emotional component of their reactivity. Colleagues and therapists could normalize the presence of emotions that implied less than therapeutic attitudes. Therapist 4 emphasized repeatedly that colleagues allowed him to accept his anger as a legitimate reaction, first by experiencing what he had disowned: “And it was interesting
watching their anger as I was explaining the situation because they were getting angry on my behalf.” Therapist 7 noted that her own therapist’s increased willingness to show human vulnerability gave her permission to do so also, both to herself and to her client. Her client’s previous therapist also legitimized her emotional reactions of feeling overwhelmed and dissociated. Therapist 10 knew that her colleagues could accept her exasperation because they had often expressed the same regarding their own challenging clients. Therapist 12 described safety in her collaboration with another couples therapist as key to confronting her reactivity: “I felt I was in a shared enterprise and it wasn’t all on me, and that gave me the ability, not so much in the sessions we were doing, but outside the sessions to feel safe enough I guess to explore my own reactions to her.”

It should be noted that none of this acceptance seemed to prevent the therapists from accepting responsibility for managing their reactivity, or from acknowledging and exploring their own contributions to it. In all four of these cases (1, 4, 7, 12), therapists delved or had already delved into their childhoods to learn what caused this particular client to elicit such powerful reactions, and how these reactions could be turned toward contact. Colleagues helped them to make connections among the components of reactivity outlined in the core narrative: their own interpersonal history; their consequent psychological needs and interpersonal tendencies; their cognitive-emotional reactions; their behavior toward their clients; their clients’ behavior toward them; their clients’ similarity to themselves or important people in their lives; their clients’ interpersonal history, context, and related needs. One narrative that brings many of these together is that of Therapist 7, put together in previous therapy:

I think that part of my wounding has been that I am able to connect with people on is when they haven’t felt held enough or touched enough. I think actually a lot of what my parents did was fairly standard in terms of what I hear from so many people who experience all of our wounding, that we rarely get that gleam enough or are held or
nurtured enough. But I think that the more powerful wounding for me was when she had that stillborn, I think that there was powerful emotional denial and suppression that I engaged in as a two year old, and so I think that I am very sensitive to internalized stress.

Most interesting in its connection to recent developments in theory about countertransference, is the parallel process whereby therapists internalized valuing relationships that could then be offered to clients (1, 7, 12), who in turn had the opportunity to internalize them. For therapist 1 this valuing relationship was developed in the context of practicing tonglen. Although no one else was present during this practice, the effect was essentially the same as that of a valuing relationship. Therapist 1 was both the conveyor and receiver of compassionate attention. Not only did she offer the client the same compassion through the same method, but she explicitly taught the client a version of tonglen designed to help her develop compassion for herself.

Therapist 12 also described safety in her marriage as facilitating reactivity management: “...just being in a relationship where I feel secure and I feel like...he knows the worst of me and we’ve gotten to the point in our relationship where we can confront each other so I feel safe in that sense that I can trust him to do that. Thus safety from invalidation allowed her to be honest with herself.

Valuing relationships provided safety from other interpersonal threats as well, both for therapists and clients. Therapy dyad 1 was concerned with safety from abandonment; Therapy dyad 7 was concerned with safety from painful contact, on the client’s side, and safety from abandonment, on the therapist’s side. None of these concerns is mutually exclusive; any time one experiences a relationship as non-valuing, elements of abandonment, pain, and judgment can be present. Conversely, the valuing relationship passed on by the therapist combines being present with being accepting.
Therapist Self-Awareness Practices

Several therapists (4, 5, 12) mentioned routine behaviors they had established to help them become aware of their reactivity. Consultation has already been considered in the context of relationships; here, reflection, meditation and self-care are discussed.

For some therapists, reflection times were not structured but more free-floating, allowing connections to be made while in a state of mild distraction, such as while driving (12) or in the shower (5). Therapist 12 described this process: “I think about clients throughout the week. I don’t obsess about them, but a client will come into my mind and I’ll connect that with something.”

Other therapists were more structured. Therapist 4 typically reviewed notes before sessions, so that with clients who triggered personal reactions, he could prepare his approach. Therapist 6 stated that prior to sessions she would:

…see what can I have some compassion about, because if I can kind of find that and hold that then I’m not so likely to be as angry….If I catch that that is kind of a feeling or a theme that is developing with the client, then I do try to remember to check that before I go in or I’ll end of getting sucked in before I know it. [Compassion] means… “where is their pain,” you know, because recognizing that we all have it. People act in a lot of ways when they are in pain and sometimes [I try to] see if there is anything I can recognize.

The above description sounds like a less formalized version of tonglen, a meditation in which negative emotions are breathed in, transformed into compassion, and breathed out. Tonglen is less cognitive – more of a felt experience – than the practice of Therapist 6, and is meant to benefit others directly. Appendix B includes a description of tonglen directly from its major Western proponent, Pema Chödrön.
Therapist Self-Care Practices

Self-care could be described as a bridge between empathy for self and empathy for the client, because therapists who were able to attend to their immediate needs for mental and physical rest viewed their renewed energy as instrumental in being able to make or sustain contact with their clients: “It is more of an intentional out. That is what I have learned that there is a contact and withdrawal cycle, and I have just contacted people for you know three hours in the morning or 3 ½ hours and I need a break.” Other ways Therapist 7 renewed her energy included taking naps, reading books unrelated to psychology, going to conferences, and limiting the number of clients seen per day. Therapists 3 and 4 prepared themselves by taking extra time before their challenging clients. None of the other therapists described such efforts at self-care. Perhaps the connection between self-care and reactivity management was not direct enough for these therapists to recognize it, or perhaps they were less likely to care for themselves regularly and deliberately. This connection may be worth further exploration, as it makes intuitive sense that a therapist who is rejuvenated by physical and mental rest will be more likely to sustain contact with self and other, however emotionally charged. This logic depends on a key theoretical assumption not evident from the data: that a positive relationship exists between reserves of mental and physical energy, and willingness to engage in reactivity management.

Client Factors Facilitating Reactivity Management

It can be easy to focus on the therapist’s traits, beliefs, practices, and relationships that facilitate management of reactivity, while ignoring the potential role of the client and the client’s relationships. Clients may bring some of the same qualities as therapists can bring, such as patience, commitment, insight, and willingness to be open. Clients may also bring their
psychological needs, which by triggering therapists’ reactivity create the opportunity for awareness of mutual reactivity. Ultimately, for any therapy to weather the process of working through reactivity, be it the therapist’s, the client’s, or a combination of the two, both people must stay the course and cope with potential discomfort.

Therapist 1 found that “there was some part of” her client that realized that the therapist couldn’t merge with her. Thus a healthy component of the client may be receptive to the therapist’s efforts to move away from enmeshed or distant forms of contact to an empathic but separate stance, i.e., a corrective relational experience. The same client may be able to express psychological needs that do not acknowledge limits but help the therapist perceive and empathize with the client’s psychological wound: “I could feel the hunger in her for [acceptance].” In a similar vein, Therapist 10 saw her exposure to the client’s neediness as a turning point: “She was very depressed and I went out to see her at her apartment and kind of saw how she lived and saw how little she had in terms of, not just material possessions, but companionship. I had a lot more empathy for her.”

Several therapists (2, 3, 12) identified traits in their clients that might be seen as manifestations of ego strength. Therapist 2 noticed a motivation for health in his client that helped him balance his personal wish to replace the client’s father with his therapeutic commitment to her growth: “she was desperate to be an independent person at the point of which her father died.” Therapist 3 stated that her client “had a lot of faith as it turned out. …I think what kept me from feeling helpless was a sense that she thought…I knew what I was doing.” Therapist 12 also showed respect for her client’s strength: “To her credit, she’s very resilient, you know. She bounced back from any confrontation. And she’d always come back and kind of
get in there again, so she’s very feisty and really a survivor… she was very devoted to the therapy, and no matter what happened, she’d be back like clock-work.”

Finally, several clients manifested their strength in confronting their therapists with their reactions to therapist behavior. Therapist 5 saw this as necessary to resolving an impasse that eventually helped his client gain in insight and ability to tolerate imperfect empathy. His client “confronted me with genuine and realistic issues and challenged me to be a better therapist…which not all clients would, they don’t really have the strength to do that with a therapist, but this client would.” Therapist 4 noted that his client’s parents were pushing aggressively for a more genuine response: “And [the mother] even commented later on…down the road, ‘You wouldn’t engage us…you wouldn’t connect.’” When Therapist 3 expressed curiosity about her client’s desire to make contact rather than seek refuge in dissociation, her client had the courage to “respond to that real clearly, she said, ‘I want you to move in.’”

A few therapists noted that their clients’ social supports allowed them the safety to respond positively as their therapists worked through their reactivity and were able to challenge them. Therapist 2 saw how his client’s relatives provided her with the parental presence that allowed him to step down his own parental role. Therapist 7 emphasized the importance of her client’s Intensive Case Manager, who dealt with the many practical problems in the client’s life so that the therapist and client could concentrate on the therapy relationship. Therapist 12 saw the client’s religious activities as bolstering her when the therapist was able to empathetically confront central issues like inadequacy and not being heard. Neither therapist nor client operates in a social vacuum. Just as dysfunctional relationships can engender or exacerbate unmet psychological needs in both therapist and client, so too can functional relationships help to meet such needs or provide the sense of safety that allows each to tolerate self-exploration.
Relationships Among Facilitators

What are the possible interconnections among facilitators of reactivity management? Three sets of relationships can be examined: those among internal facilitators, such as traits, beliefs, and prior resolution; those among facilitators external to the therapist, such as client factors and personal and professional relationships; and those between internal and external facilitators.

Looking at the first set, Therapist 8 stated, “My own temperamental experience and my own theoretical and training experience and my own personal experiences, they’re all mixed together. It seems to happen that way.” This statement seems to describe integration; this and others made by this therapist imply that beliefs and experiences affirm rather than contradict each other, and that personal qualities over time have become available to creative use, rather than defensively standing in the way of therapeutic engagement. Therapist 3 alluded to a similar process in her description of gestalt becoming integrated and natural to her. One key conclusion to be made from this example is that reactivity management may be a conscious process, but it is supported by self-development that has already occurred and cannot be willfully executed. Therefore therapists who wish to become adept at identifying, exploring, understanding, and responding to their reactivity would do well to engage in overall psychological growth and integration processes, whether they be through therapy, supervision, workshops, or personal relationships. These recommendations will be discussed in further depth in Chapter XI.

External facilitators may have a synergistic effect when they provide similar corrective experiences or interpersonal insight. For example, Therapist 12 mentioned how both colleagues and her husband provided the validating presence that allowed her to explore her reactivity.
Therapist 4 described complementary forms of assistance provided by different colleagues with whom he consulted, such as containment for his anger, guidance in exploring sources of his reactivity, validation of his clinical decisions, and help in identifying therapeutic strategies.

Internal and external facilitators are related in the sense that therapist attitudes about the importance of personal and/or professional relationships to self-awareness, empathy, and resolution of reactivity support the use of these relationships when reactivity is triggered. In turn, the prior cultivation of such relationships allows for such cognitive and experiential change. By offering the reasons for and means to managing reactivity, all of the management facilitators may converge to support the core corrective experience described in depth in Chapter VII: the shift from reactivity to responsiveness.
Chapter VII

THE CORE CATEGORY: THERAPIST REACTIVITY MANAGEMENT

“I’m aware of my own discomfort at being caste in this sort of a way, such that I thought it’d be more valuable if both of us could in some ways work toward trying to take the risk … of being more real or more authentic….”

-- Therapist 9

Introduction

Therapist management of reactivity is the main focus of the present research. From a research perspective, the actual process of managing personal reactions to clients has remained a mystery, one that I have felt highly motivated to explore as a psychotherapist interested in both gathering clinical wisdom and making it available to others. Through their insight and commitment to their profession, the twelve therapists interviewed for this research offer both diversity and depth in their descriptions. The grounded theory developed from these descriptions attempts to uncover basic processes at work, without losing the level of detail needed for readers to apply theory to practice.

Defining the Core Category

Therapist Reactivity Management refers to therapists’ accounts of their activities, inside and outside of the therapy sessions, aimed at meeting at least one goal, and in some cases two. The first goal is preventing therapist reactivity from interfering in client progress. The second goal is making use of therapist reactivity in promoting client progress. This goal, not mutually exclusive with the first, takes as a given the idea that therapist reactivity can be integral to the process of successful therapy.
The reader should be aware that the core category does not directly refer to therapist activities, but to their accounts of these activities: accounts which are necessarily perceived subjectively, and which also necessarily are influenced by interactions with the interviewer. However, for the sake of clear presentation the therapist activities themselves are sometimes referred to without reference to their mediation by therapist perception or interviewer interaction. The reader is asked to keep in mind the subjective nature of the entire research endeavor.

Key ideas of the grounded theory relevant to the reactivity management process are:

1. Therapists who manage their reactivity successfully undergo a process of exploration to reach an empathetic understanding of their reactivity, their clients’ reactivity, and the interaction between the two.

2. An empathetic understanding of reactivity is based on identification of human needs that are being threatened, and sometimes includes the interpersonal history of those needs.

3. Empathetic understanding of self and client helps therapists to avoid acting out reactions to client reactivity.

4. Therapists’ empathetic understanding of themselves and of their clients may help them to either transcend or control reactions, or both.

5. Therapists’ empathy for self may help to increase empathy for their clients and vice versa.

6. Self-valuing and empathetic understanding of their own reactivity allow therapists to understand and value their clients when they would otherwise be judgmental.

7. Wounded healers use their vulnerability to reactivity in order to connect with clients and help them accept themselves and be in contact with the therapist and others.

8. Relational experts contain or transcend their reactivity in order to connect with clients and help them learn to handle interpersonal situations differently.

9. Both wounded healers and relational experts usually need to monitor and control their reactivity once they have understood it.

10. Both wounded healers and relational experts may share their cognitive-emotional reactions to clients once the contribution of therapists’ own interpersonal needs is understood and set aside.
Overview of Reactivity Management

In order to keep the whole process in mind, the outline of reactivity management follows.

Figure 9: Outline of Reactivity Management and Use

Management Facilitators

1. Therapist has already established one or more of the following that facilitate management and use of reactivity
   a. professional and/or personal relationships;
   b. self-care practices;
   c. self-awareness practices;
   d. therapist responses and attitudes toward their reactivity;
   e. theoretical/experiential training and/or theoretical concepts;
   f. prior understanding/transcendence of reactivity.

2. Client has one or more of the following that facilitate therapist’s awareness of reactivity:
   a. assertiveness in confronting therapist or acting out reactions;
   b. relationships that illuminate client reactivity;
   c. relationships that support client functioning and allow therapist to focus on reactivity.

Internal Management of Reactivity

3. Through management facilitators, therapist becomes aware of some aspect(s) of reactivity.
4. Therapist decides to manage reactivity based on commitment to client’s development.
5. Therapist explores reactivity through consultation, awareness practice, or contact with client’s social context.
6. Therapist reaches empathetic understanding of own reactivity and/or client reactivity and/or their interaction and/or their common roots in psychological wounds and/or needs.
7. Through empathetic understanding of self and/or client, therapist may contain cognitive-emotional reactions.
8. Through empathy and/or valuing contact with self, therapist may transcend cognitive-emotional reactions.
9. Through containing and/or transcending cognitive-emotional reactions, therapist is able to avoid psychological defenses or reactive behavior.
10. Therapist may continue to monitor self for cognitive-emotional reactions, psychological defenses, and interpersonal tendencies.

**Interpersonal Responsiveness/Use of Self**

11. Therapist may share empathetic understanding of client’s reactivity.

12. Therapist may disclose own reactions to client’s reactive behavior.

13. Therapist may express congruent empathy for client.

14. Therapist may provide valuing contact to client.

Therapist efforts to manage their reactivity can be broadly divided into two main categories: internal management and interpersonal responsiveness/use of reactivity. *Internal management* includes both cognitive and experiential change. Cognitive change includes identification, exploration and empathetic understanding of reactivity. Experiential change comprises empathy for self and client, and transcendence of reactivity through a corrective experience. *Interpersonal responsiveness/use of reactivity* may include overlapping aspects of the wounded healer and the relational expert roles, each of which may include sharing empathetic understanding of the client’s reactivity, disclosing one’s own reactions to the client’s reactive behavior, congruent expression of empathy, and making valuing contact with the client.

How are these broad areas interrelated? Cognitive change is always the first step in reactivity management, naturally moving from recognition of a problem to exploration and understanding. Although this step is defined by shifts in therapists’ cognitive models of their reactivity and its interpersonal and historical context, this is not to say that emotions do not accompany or influence this work. Uncomfortable emotions often precipitate exploration, and new understanding of self, client, or the therapy relationship may result from willingness to experience uncomfortable emotions.
Therapeutic behavior follows from cognitive change in two ways. First, therapists who recognize their reactivity can then decide consciously to place their clients’ needs before their own. Second, therapists who understand their reactivity in relationship to their clients’ reactivity can then use this understanding to help clients develop insight. Often this new understanding is more empathetic than clients’ previous interpretations of their behavior.

Experiential change comes about as some therapists go beyond new understanding to a new relationship to themselves. This new relationship is usually characterized by a corrective experience of accepting themselves and feeling compassion for their own suffering. This experience may be difficult to distinguish from the empathetic understanding of reactivity that results from cognitive exploration, and in fact the two may not be sharply dichotomous. The main distinction seems to be that therapists who underwent experiential change ended up feeling changed, as opposed to having a changed perspective on something about themselves.

Some therapists who experienced experiential change also engaged in use of self as wounded healers. Use of self implies that therapists are being transparent in some way, letting their clients see their humanity, whether this be psychological vulnerabilities or genuine caring for their clients beyond a professional commitment. In this sample most therapists who engaged in cognitive work regarding their reactivity but did not describe an experiential change, engaged in therapeutic behavior that stopped short of use of self.

Internal Management of Reactivity: Cognitive Work

To varying degrees all of the therapists engaged in some cognitive work to manage and/or use their reactivity in the interest of their clients. This work can be divided into three activities: identifying, exploring, and understanding reactivity. Empathetic understanding
extends not only to the whole complex of reactivity including the client’s contributions, but may also make sense of the place of that reactivity in the process of the therapy as a whole.

**Identification of Reactivity**

What typically initiated identification of reactivity was an uncomfortable emotional or visceral response to the client that seemed to push for expression in a manner that might be counter-therapeutic. In other words, the reactivity drew attention to itself because it was unpleasant and/or contrasted with therapeutic aims. One might view emotions and visceral sensations as signals calling for attention or action. Given that subtle emotional reactions to clients are common, how closely therapists attend to them may depend on some of the facilitators addressed in the previous chapter: beliefs about personal reactions and their role, or previous exploration. Therapist 1 spoke of developing a stronger appreciation for her subtle reactions once she learned that her first feelings toward her client had presaged the difficulties of that therapy.

In the process of exploring their reactions, these twelve therapists universally became aware of emotionally charged tendencies toward action with their clients. Therapist 1 could not feel empathy toward her client, felt threatened by her rage, and felt like controlling her. Moved by his client’s loss, Therapist 2 felt drawn to be a father to his client, to step beyond professional boundaries. Therapist 3 became aware of her frustration with her client for being so easily triggered into dissociative episodes, and of her tendency to be overly cautious. Therapist 4 felt intense anger that wanted to express itself in cursing the client’s parents, and did let himself do so while jogging. Therapist 5 felt like atoning for a great sin when confronted by the client. Therapist 6 felt repulsed by the client’s apparent narcissism and regretted accepting him as a client. Therapist 7 felt overwhelmed, deadened, and frustrated by the client’s silence. She wanted
to express her impatience and get her client moving. Therapist 8 felt torn, wanting to shock his client and at the same time to avoid anything shocking. Therapist 9 felt complacent, like basking in the client’s praise, and later ashamed, like defending himself. Therapist 10 felt annoyance, and considered referring her client to someone else. Therapist 11 felt inadequate, and felt like telling her client she asked for more than the therapist could give. Therapist 12 felt reactive – frustrated and judgmental – and felt like tuning her client out. These reactions all indicated to the therapists that something was potentially counter-therapeutic in their actions or feelings requiring further exploration or self-monitoring. The common theme of emotionally charged tendency toward action suggests that in order to become aware of reactivity, therapists can initially ask themselves, “What do I feel like doing for or to this client?”

Another trigger for observation of reactivity in several cases was the resemblance of the client to someone important in the therapist’s life. In the first session, Therapist 1 identified her client’s vegetative depression as similar to her own mother’s. Therapist 2 recognized immediately that his client was his daughter’s age and sought some of the same responses his daughter sought from him. Therapist 8 knew immediately that his client resembled his mother in personality and values. Therapist 10 saw characteristics in common between her client and her former mother-in-law that gave her pause but also helped her process her reactions. Therapist 11 identified an uncanny resemblance between her client and her grandmother who had committed suicide.

The helpfulness of physical or behavioral resemblance in cueing therapists to anticipate and circumvent their difficulties appears to be strongest when the therapist is not the person being identified with the client: “She gets referred to me and I am approximately her father’s age…. I had to establish what I thought was a working relationship while being mindful of what
could be this kind of quasi father/daughter relationship, so there was a certain juggling and attention to that that I had to pay.” Therapists 1, 2, 8, 10, and 11 knew early on that their clients were likely to evoke certain feelings, and were able to avoid most behavioral manifestations. Therapist identifications with clients (1, 7, 9, 12) tended to come to awareness more gradually and followed observation that unpleasant emotions or defensive reactions were evoked. Therapist 12: “I sort of realized over time that she did really reflect a lot of the struggles that I had had, although we’re very different personality-wise.” This distinction may imply that therapists need to be more proactive in discovering how their clients resemble them, especially in less tangible ways like defensive tendencies, while resemblances to important people in therapists’ lives may surface more easily.

It is impossible to determine exactly which components of the therapist reactivity or mutual reactivity (actual or anticipated) different therapists became aware of as an initial incentive to explore and manage their reactivity. Even if the investigator returned to participants with such a question, it might be difficult for them to reconstruct in retrospect, after more of these components had come into focus. In learning from these therapists’ experiences it seems helpful to consider any of these components – therapist’s interpersonal history or needs, therapist’s needs being threatened or gratified, therapist’s cognitive-emotional or behavioral reactions to client, client’s interpersonal history or needs, client’s needs being threatened or gratified, client’s cognitive-emotional or behavioral reactions to therapist – as a potential entry point into exploration, understanding, and management of reactivity.
Exploration of Reactivity

Initial awareness motivated all of the therapists to explore their reactions, though some therapists needed – or were inclined to – more exploration than others. Some of these therapists sought consultation (1, 4, 6, 7, 10, 12) and others engaged in reflection (2, 3, 5, 8, 9, 11). Ways in which consultation and reflection promoted exploration have been discussed in Chapter VI. Exploration ranged from a quick identification of the source of the reaction (2, 3, 5, 6, 8, 10, 11), to a more thorough exploration of interpersonal history and its influence on the therapist (1, 4, 7, 9, 12).

For some of the therapists (2, 8, 10 and 11), being able to identify the source(s) of their reactions was enough to loosen their grip. Therapist 8:

When I am able to sort of intellectually conceptualize it in that way, that defuses it… I mean I think if it weren’t finished in my own body and soul in some way, then I’m sure it would be more difficult to be able to say, “Ah, that’s what going on.”

Those therapists who required intellectual understanding and seemed to require no further self-exploration to respond therapeutically, either appeared to have processed the source of the reaction on an emotional level previously (Therapists 8 and 10), or seemed to have had a less emotionally powerful trigger to begin with (Therapists 2 and 11). For the others, a concerted effort was necessary to control reactions by pushing toward greater contact with the client.

Therapists did not describe a detailed process of exploration of their reactivity, other than many noting that they achieved a greater appreciation of the impact of their personal history on their current reactions (Therapists 1, 4, 5, 7, 8, 9, 10, 11, 12). Generally these therapists did not convey the sense that their insights came as great surprises; instead, many seemed to draw easily from a coherent personal narrative to explain how they were reactive to a particular client, at least in retrospect. At the same time, a number of therapists described how their awareness of the
sources of their reactivity took time to form (1, 3, 4, 7, 8, 12). Taken together, these two
observations suggest that connections that seem obvious in retrospect may take time to surface,
even when supported by practices of reflection and consultation.

Although the process of self-exploration remains fairly opaque (for example, we do not
know what questions therapists ask themselves beyond, “What’s going on here?”), the content of
such an effort is more accessible from the interview data. One may take the reactivity section of
the grounded theory flowchart (Figure 5, p. 123) to be the domain of exploration. A thorough
understanding of reactivity would include all of the subcategories represented in Figure 5, as
well as potential causal relationships among these categories. Sometimes therapists’ accounts
omitted mention of some categories, but they may be implied by the logic of the accounts. For
example, therapists rarely speculated on the internal reaction of the clients to the therapists’
reactivity, although an internal reaction is always implied in reactive behavior.

Mutual reactivity is a special case of reactivity, in which therapist and client reactions set
each other off in a positive feedback loop. Exploration of this cycle requires the therapist (1, 3, 7,
12) to see self and client as both vulnerable to the pressure of psychological needs. An attitude of
acceptance toward both self and client allowed therapists to explore and understand reactivity
and its relationship to mutual responsiveness. Therapist 7:

I knew she was feeling powerful anger and that here she is sitting there curled up in a ball
in the room showing no signs of anger at all and showing signs of terror. So I knew that
also, wow, if I am feeling this much frustration and anger and wanting to shake her, how
much of that is what she is really needing to get in contact with and how much of that
could mobilize her from her current position of being “safe” in her enclosure, but very
vulnerable and not alive in the world.

I could say in general that it [what got pulled from therapist’s personal history] was
dealing with all of those emotions. You know, how do I deal with my anger in a healthy
way. How do I deal with my rage and certainly on how do I deal with my sadness. How
am I as ill as she is, you know.
Empathetic Understanding of Therapist and Client Reactivity

Empathetic understanding may be defined as a shift in how a therapist views the therapy relationship, the client, or some aspect of emotional experience. The purposes of understanding are to free therapists to respond rather than react, and to help clients understand their own processes in order to engage in more productive ones.

The previous sections on awareness and exploration of reactivity focused on processes of arriving at a new understanding of reactivity. In addition to exploration through consultation and reflection, new understanding may come about through the application of theory (3, 6, 7, 9, 12), transcending reactivity through experiential change in relation to self (1, 5, 7, 12), or a combination. Application of theory was addressed in Chapter VI in the section on training and theory as management facilitators, while experiential change deserves a section of its own because it encompasses several processes.

Therapists reached several different kinds of understanding regarding their reactivity. Winnicott (1949) distinguished between subjective and objective reactions: those that are more heavily influenced by a therapist’s own interpersonal history, and those that are more predictable reactions to a client stimulus. All but one of the therapists (6; see discussion below) recognized the double origin of reactivity in both their own past interpersonal experiences, and client influences.

Racker (1957, 1968) first made the distinction between complementary and concordant countertransference reactions, based respectively in identification with the client’s objects – internalized significant figures to whom the client developed patterned responses – or with the client’s introjects – internalized objects with whom the client is identified. Some therapists identified shared reactivity grounded in similarities between themselves and their clients, and
used this common ground to better understand and empathize with their other clients. Others recognized complementary interpersonal reactions and, if needed, worked to separate subjective and objective aspects of these reactions: “I don’t think I had to do more than recognize that I know where that comes from in me, I know what that’s about, and it’s not her” (Therapist 3).

The relationship between empathy and understanding of reactivity is useful to explore. In Chapter IV, empathy was defined as “a form of contact in which what is valued and experienced by the therapist is the client’s or the therapist’s own suffering related to psychological wounds.” A psychological wound is defined as “an aspect of interpersonal history that is currently experienced as suffering (the opposite of well-being) when it is in awareness. The wound is often related to a chronic disruption of valuing contact that resulted in psychological defenses and interpersonal tendencies that reduced the possibility of contact in order to reduce suffering. The wound may be inadvertently re-experienced through repetition of behavior meant to minimize suffering.”

The therapist must understand the client’s psychological wound – not necessarily how it came to be, but how it is experienced by the client – in order to empathize. Therapist 1 describes this connection:

…which gave me great compassion as I thought of what it would be like in every interaction to feel that depth of feeling, which I think was the way she walked around in the world.

Therapist 8 offers another example:

I liked her a lot more. I certainly was able to kind of appreciate her and get a sense of “Okay, yes, she was a little prim, but there were reasons for that and for all of us there are.” So that…I think I became more able to see her as a sort of multidimensional being.

Therapist 12 made a connection between empathy and managing reactivity:

By the time I can connect with her and develop empathy for her, and allow myself to align more with that part of her that is healthy and is trying to really be heard, then
[reactivity] is almost not even an issue. It’s not like I have to deal with a lot of containing then. I think the route to the containing is the empathy, which for most clients is pretty easy to come by. You hear enough of their story and it’s there.

Therapist 6 described how she intentionally set herself up to empathize with her client:

“It’s like from my corner of the world, from my perspective can I recognize anything in them that I imagine causes them pain, even if they don’t know it….You know because if I can see that and hook to that then, you know it will help me get past reacting to them.”

In parallel fashion, Therapist 12 suggested that the same process works toward self as well as other: “being compassionate with myself allows me to look at that stuff. You can’t look at that stuff if you’re self-critical.”

Whether directed inward or outward, empathy seems to have two different stages: potential and actual. For Therapists 6 and 12, empathy meant a willingness to understand and care about someone (self or client) as a suffering human being – “what I would do would be to see what can I have some compassion about, because if I can kind of find that and hold that then I’m not so likely to be as angry” (Therapist 6). For Therapists 1 and 8, empathy meant the understanding and caring itself, once the person’s suffering is known. An empathetic attitude toward both self and client would seem to spring from a more generalized empathetic understanding of suffering as a universal human experience. I now turn to the ways in which this understanding differed depending on how therapist and client suffering interacted.

For some therapists it was important to recognize reactivity shared by therapist and client (1, 7, 9, and 12) due to similarities in interpersonal history (concordant reactions). Through practicing tonglen, Therapist 1 “understood hostility, real rage and anger, and the unrecognized hurt that probably was under that for her as it was under that for me.” Therapist 12 observed that this parallel wasn’t evident at first: “I sort of realized over time that she did really reflect a lot of the struggles that I had had, although we’re very different personality-wise.” Therapist 9
identified the function of reactivity in common between self and client: “It was in my awareness that it was probably serving a defensive purpose for both of us in terms of avoiding what was actual.” For Therapist 7, finding psychological wounding in common meant asking, “How am I as ill as she is?” For these therapists, recognizing this common ground of human suffering was useful both in understanding and empathizing with clients.

When therapist reactivity was complementary rather than concordant, new ways of looking at client reactivity were also pivotal in shifting from reactivity to responsiveness. Several therapists found that their understanding of their clients’ reactivity as a lived emotional experience and means of responding to a psychological threat (1, 6, 10, 12), rather than as a threat to the therapist, helped them to develop empathy for their clients. Therapist 12 arrived at such an understanding:

And she was really trying to hold on to herself. Her experience growing up was that her family never believed what she said. She was the one in the family who saw the truth, no one ever believed her, and so she felt like she was going to disappear. She felt she didn’t exist. And her only way of coping with that was to scream and yell, you know, I’m here, listen to me. So it was very, you know, kind of a healthy motivation behind it.

In similar fashion Therapist 1 “understood that rage, anger was her [client’s] only way of being able to stay standing, of not collapsing.” This example of client reactivity was both concordant and complementary, in that the therapist was both a target for and experienced such anger within herself.

Sometimes identifying the psychological need or threat generating their own reactivity was helpful to therapists in not responding in complementary fashion to client reactivity. For example, Therapist 11 was able to prevent herself from meeting her client’s dependency wishes and challenge her more, once she understood the origin of her rescue fantasy in her own family history:
People in those days didn’t know how to treat a sudden depressive episode, which is what [my grandmother] had, and so she died in a really horrible way. And…when I realized that [my client] looked like my grandmother reincarnated, it was a shock to me. It was like, ‘Oh my God.’ And I wondered if part of my pull to rescue her was tied back to that. You know that event in my family, that person whom I was unable to rescue.

As mentioned, all of the therapists but one identified some aspect of their reactivity originating in their interpersonal history. These origins are described in Chapter V. Therapist 6 saw her impatience as influenced by her tendency to be goal-oriented, but did not identify the source of this tendency, nor any personal origin in her initial repulsion toward her client. This example is important in that it demonstrates the possibility that a therapist’s reactivity is rooted in universal reactions rather than idiosyncratic ones. Perhaps all therapists would be repulsed by narcissistic behavior. Controlling reactivity need not be an exercise in introspection, if empathic understanding of the client is enough. Another gradation of insight is provided by Therapist 8, who identified the personal origin of his reaction quickly, but never fully defined the nature of the threat, only saying that the desire to shock represented a wish to connect, i.e. make contact. This example demonstrates that some defensive behaviors which have already been explored may be given up without unearthing the underlying threat.

For therapists to set aside their own impulses to react in complementary fashion, they could also seek an understanding of how their reactivity differed from what their clients needed. Therapist 2 fully articulated this understanding:

I resisted that [savior mentality], of course, as there was no future in it. She really needed to discover what she could be independently now that she had no father in her life anymore, break away from that…. I would probably be keeping her from learning to do the things that she is going to need to do for the rest of her life, because I am not going to be around her whole life.

Therapist 3 saw the need to transcend her fear of her client’s rage, because “it’s real important that I be a container for this rage, to be a safe place for her to have that.” Therapist 4 identified
the opposite problem, of being too accepting: “I do have a nature or history of underreacting. I’m very calm in stressful situations. When pressed I should be more reactive.” Therapist 8 contrasted a reactive, child-to-parent reaction with a collaborative, adult-to-adult interaction: “You get a sense of competence by being able to recognize that I don’t really need to provoke her. I can go and be her equal in a sense.” Therapist 9 saw the contrast between reactive avoidance and responsive engagement in nonverbal, embodied terms:

And, the remedy for it was going to be to almost sit up straight, get engaged more realistically…I mean the difference between complacency is kind of sitting there [leans back] or energetically being much more alert and engaged actively with somebody.

Universally, the main shift in therapist behavior came about as a result of identifying, understanding, and surrendering a defensive stance, while adopting an open stance of greater empathy, personal vulnerability, or intimacy. This change could occur through empathetic understanding alone (as described above), or require an experiential change in relating to self, as will be discussed further on. Figure 10 identifies the reactive and responsive stances, as well as the main focus of defensiveness, for each therapist.
Figure 10: Therapist reactivity versus responsiveness

<table>
<thead>
<tr>
<th>Ther.</th>
<th>Reactive stance</th>
<th>What is defended against</th>
<th>Open stance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Contain client's anger</td>
<td>Hurt, emotional paralysis</td>
<td>Empathize w/ client’s anger</td>
</tr>
<tr>
<td>2.</td>
<td>Be a caregiver</td>
<td>Retraumatizing client</td>
<td>Support autonomy, be container for grief</td>
</tr>
<tr>
<td>3.</td>
<td>Avoid intrusiveness</td>
<td>Retraumatizing client</td>
<td>Engage withdrawn client</td>
</tr>
<tr>
<td>4.</td>
<td>Respond calmly to anger</td>
<td>Appearing defensive</td>
<td>Express anger constructively</td>
</tr>
<tr>
<td>5.</td>
<td>Maintain rigid self-standard</td>
<td>Not being perfect</td>
<td>Acknowledge errors, explore client’s reactions</td>
</tr>
<tr>
<td>6.</td>
<td>Push for progress</td>
<td>Lack of contact, helplessness</td>
<td>Disclose own responsiveness</td>
</tr>
<tr>
<td>7.</td>
<td>Punish silence with silence</td>
<td>Helplessness</td>
<td>Disclose reactions</td>
</tr>
<tr>
<td>8.</td>
<td>Avoid intimate topics</td>
<td>Aggressive reach for contact</td>
<td>Explore intimacy</td>
</tr>
<tr>
<td>9.</td>
<td>Deflect intimate contact</td>
<td>Shame, feeling inadequate</td>
<td>Disclose shame, stay in contact</td>
</tr>
<tr>
<td>10.</td>
<td>Silent judgments</td>
<td>Hurt of previous marriage</td>
<td>Empathize with pain</td>
</tr>
<tr>
<td>11.</td>
<td>Rescue from depression</td>
<td>Helplessness, ineffectiveness</td>
<td>Empower to cope</td>
</tr>
<tr>
<td>12.</td>
<td>Avoid exploring victimhood</td>
<td>Feeling deprived, envy</td>
<td>Empathize with victimhood</td>
</tr>
</tbody>
</table>

Understanding client reactivity as the proper focus of therapeutic intervention versus something to be managed (1, 7, 8) also proved liberating. Therapists 1 and 7 had to shift away from frustration toward the client’s reactivity. Therapist 1 realized that “the hostility was the work. Holding the hostility was the work, it wasn’t… ‘How do we get her to stop that so we can do the work, because I don’t like being yelled at.’” Therapist 7 learned to tolerate her client’s silence by recognizing that “I really have something useful here that it very powerful and it doesn’t have to defeat me…. There is every reason as far as I can see to let her experience… her resistance, and to experience her dilemma of seen/not seen.” Therapist 8 saw beyond his
tendency to collude with his client in avoidance: “…this was somebody who by her sort of emotional frigidity kept people away from talking about those sorts of things, and that was the real problem.” By understanding their own reactivity, these therapists were able to see past it to the client’s reactivity as a manifestation of their basic problem, and engage this reactivity.

In summary, cognitive work is a process of identifying reactivity and its contexts in the therapist’s life and the therapy relationship, and arriving at a new, empathic understanding of self and/or client that helps the therapist control reactivity. Cognitive work may set the stage for experiential change in which therapist needs are transcended rather than controlled; cognitive work may also provide a platform for therapeutic behavior.

**Monitoring and Controlling Reactivity**

Almost all of the therapists (except Therapist 5) described efforts to monitor and control their reactivity, including those who underwent an experiential change in the process of engaging their reactivity. Therapist 5 described the resolution of his reactivity as a watershed event that led him to let go of unrealistic expectations of himself and accept therapeutic ruptures as inevitable and even useful: “That day I found out that it [a misunderstanding by therapist] doesn’t just rupture the relationship….So that was transition for me, and actually helped me open up a little bit in working on the idea that if you make mistakes in therapy that’s okay. You know it’s not whether you make mistakes, it’s what you do with it afterwards.” It is unclear from the interview whether he needed to further monitor his tendency to be perfectionistic.

Self-monitoring suggests that the therapist’s reactivity has not been fully transcended but to some extent must be contained in order to respond to clients’ therapy needs. The following
examples demonstrate how monitoring and controlling reactivity may serve several therapeutic goals.

The continued use of *tonglen* on the part of Therapist 1 prevented her from falling back into self-protective anger and the struggle not to express it, instead allowing her to feel and express empathy. Therapist 2 reminded himself frequently of his role as therapist, and titrated how much fathering he allowed himself to do. Therapist 3 controlled her self-doubt by encouraging herself, helping herself notice the good work she was doing. This encouragement allowed her to project the confidence that her client seemed to need to trust the therapy process. Therapist 4 planned consciously how to express his reaction therapeutically rather than slip into the default of being preternaturally calm. Therapist 6 used the validation of her study group to stay the course with her schizoid client and calm her impatience. The ongoing effort of Therapist 7 to monitor and control reactivity was complex: to be aware of visceral and emotional reactions, separate out the part originating in her own life, and use the part springing from projective identification to make contact with the client’s experience. In a similar manner, Therapist 8 contained his reaction while still using it to understand his client and respond to her. Therapist 9 fought the urge to slip into deflection of contact, knowing this was his tendency. Therapist 10 repeatedly set aside her own pain to attend to the client’s pain. Therapist 11 monitored her desire to rescue her client from depression, and instead tried to empower her. Therapist 12 “held” herself in the sense of compassionate awareness of her reactions (not unlike Therapist 1) and this compassion allowed her to respond with empathy rather than envy and judgment.

Taken together, the examples above demonstrate that monitoring and controlling reactivity helps therapists develop and maintain relationships with clients that are empathic, genuine, and valuing. In other words, use of self is facilitated not only by experiential change
(described below), but by monitoring and controlling one’s reactive behavior as well. Reactivity when understood can also facilitate therapists’ deeper understanding of their clients. Finally, when the reactivity is rooted in self-doubt, self-talk can be useful in shoring up the therapist’s confidence.

One may ask whether efforts to control reactivity can conflict with a fuller resolution of the underlying psychological needs, or conflict with a genuine and emotionally congruent response to the client. Therapist 1 pointed to this danger when describing how she worked so hard not to express anger at the client that her empathetic statements rang false. Therapist 4 worked to overcome his tendency to control his reactivity so strongly that he could not express a legitimate response to an aggressive client:

Kept me from just commenting on some things I really wanted to. And in my mind I kept thinking, “I don’t want to sound defensive, I don’t want to appear defensive, so I’m just gonna let ‘em vent, I’m gonna interject when I can and stay calm, make my statements, but not anything that would appear defensive.” And I did that. And the defensive thing was my biggest hang-up. I was very cautious about not wanting to appear defensive…I found myself stifled almost because of that.

Therefore it seems wise to further define control of the sort that allows for greater responsiveness. Therapist 8 provides an instructive example in reflecting on his mixed feelings about addressing intimate issues with his client:

So it’s not repressing, and not denying it, and not sort of ignoring it or not paying attention to it, but sort of, as you well, as you said, I think recognizing that it is a legitimate emotional reaction that I bring to the situation and that has probably more to do with my narrative, does have something to do with our relationship in a sense that it is reflective of some sort of desire to connect. So somehow or other it means being able to kind of keep it in play without you know sort of throwing it into the mix.

This excerpt helps to clarify what type of control is required. Mixed defensive and contact-oriented motivations reflect our universal need to find human connections while avoiding psychological wounding. If the therapist can experience some safety, whether it is internalized
valuing contact or a new understanding of relationship that accepts greater vulnerability, then
defensive motivations can be set aside, and the desire to connect can be acted upon to help the
client work through the same ambivalence.

**Interpersonal Responsiveness**

Interpersonal responsiveness includes getting unhooked from complementary or
concordant identifications in order to respond in ways that help clients develop. It may be
instructive to explore how efforts to control reactivity can result in different types of
responsiveness depending on the interpersonal stance of the client. Figure 12 summarizes these
responses.

**Figure 11: Interpersonal dynamics in therapist reactivity and responsiveness**

<table>
<thead>
<tr>
<th>Client behavior</th>
<th>Therapist reaction</th>
<th>Therapist response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent</td>
<td>Gratifying</td>
<td>Supporting Maturation</td>
</tr>
<tr>
<td>Avoidant</td>
<td>Avoidant/Aggressive</td>
<td>Gently Approaching</td>
</tr>
<tr>
<td>Aggressive</td>
<td>Avoidant/Incongruent</td>
<td>Empathizing/Congruent</td>
</tr>
</tbody>
</table>

In three cases (2, 9, 11) therapists sought to balance their support with encouraging
higher independent functioning, in spite of reactivity that leaned them in the direction of being
supportive and not challenging. These therapists acted as transitional objects for their clients,
providing a solid guiding presence until the clients could sufficiently develop a sense of internal
guidance. Challenging involved refraining from meeting needs, sometimes interpreting these
needs, and demonstrating one’s own inadequacies. Therapist 11: “‘I’m here as a person who is there for you in a way that probably seems very good, you know, very wonderful because I’m giving you all my attention. But I’m not like this all the time. I’m irritable and distracted.’ Or I’d say like, ‘Well, what is there about me, that you see in me that you want?’” Of the three interpersonal orientations, dependence, aggression, and avoidance, dependence may be the easiest to collude in, because it may meet the therapist’s need to be needed. In the words of Therapist 2, “One of the adjustments is learning to not be in sense of further use to a client, and in our fantasies we sometimes think that we will be highly esteemed and endeared to our favorite clients for the rest of their lives.” Being overly supportive can be confused with making valuing contact. When dependency is encouraged, the client’s capacity for greater functioning is not valued.

Therapists met client aggression (1, 3, 4, 7, 9, 10, 12; Clients 3 and 7 were also avoidant) with efforts to control reactivity that involved either transcending anger (1, 7, 12) or overcoming fear or defensiveness (1, 3, 4, 9). Therapist 12 described transcendence well:

By the time I can connect with her and develop empathy for her, and allow myself to align more with that part of her that is healthy and is trying to really be heard, then it’s almost not even an issue. It’s not like I have to deal with a lot of containing then. I think the route to the containing is the empathy.

Therapist 3 emphasized being “consciously aware that it’s real important that I be a container for this rage. To be a safe place for her to have that. And that really gave me a sense of strength, and commitment. To not really be scared anymore.” In other words, when attacked overtly or covertly (in the case of Therapist 7, who was being aggressively shut out), therapists experienced reactions but tried to stay engaged with that part of the client that wanted contact. They did so through empathy and through understanding the anger as an expression of a need.
Therapists responded to client avoidance (3, 6, 7, 8) with efforts to control their own tendencies to collude in avoidance or become aggressive. All of these therapists felt frustrated by the lack of contact, and frustration could be expressed as either passive resignation or punishing provocation. Instead, these therapists arrived at the approach of making gentle but persistent contact and sometimes helped their clients understand their avoidance as a defense against anticipated harm:

There were plenty of times when I repeated to her that “It seems like you don’t want me to notice. It seems like you don’t want to be seen, you don’t want to be heard. Can you sit with that? What is it like for you to know that you in part create that?” I think it was said much more gently at the time and over long periods of time, and sort of slowly framing it that way for her to see that, to evaluate our relationship as contemporary and present now and how she was repeating the old patterns.

These interpretations were often grounded in therapists’ objective reactivity, once separated from its subjective aspects. As may be clear from these examples, controlling reactivity and conveying understanding often go hand in hand.

Sharing Understanding with Clients

Advocates of interpersonal therapy often extol the power of therapists offering clients their personal experience of being with them (e.g. Levenson, 1995; Strupp & Binder, 1984). An interpretation can be accepted or not, but description of the therapist’s feelings is harder to reject. Such descriptions often feel very familiar to clients from their relationships outside of therapy. The trust engendered by therapists’ empathy and valuing contact may allow clients to accept their therapists’ feelings as relevant to their own interpersonal predicaments.

In the case of these twelve therapists, such feelings were usually disclosed to clients once the objective part, or that which is largely an expectable reaction to the client’s behavior, was clear in the therapist’s mind. Therapists’ reactions were used to educate their clients about how
they reacted in current relationships in self-defeating ways. The diagram of reactivity in Chapter V (Figure 5, p. 123) maps out the connections therapists can highlight when conveying understanding to clients.

Disclosure of reactivity includes three possible content areas: concordant reactions, complementary reactions, and defensive reactions. Concordant reactions could be shared as part of expressing genuine empathy, but also as a means of connecting to the client’s experience through projective identification (Therapists 1, 7 and 9). Therapist 9:

Gee, what I’m experiencing right now as I sit with you, you know, is how I’ll start to, you know, color up and blush and feel like I almost need to get away from being experienced like this, and sort of like, I could feel like the bad me is being put right out there. The not good enough me….

Complementary reactions could be shared to help clients understand and transcend their own reactivity. Therapists 2, 3, 4, 5, 7, 8, and 9, by sharing complementary reactions, i.e. therapists’ interpersonal responses to clients’ behavior toward them, also offered a corrective experience of relationship to those clients, like 3, 5, 7 and 8, who had never been permitted to discuss feelings directly.

To review, therapists may use their reactivity to understand the dynamics of the client and the therapy relationship, in part by setting aside the subjective aspects of their reactions. This dynamic understanding can be imparted in a number of ways, often most effectively by sharing emotional reactions that are not hypothetical the way interpretations are. The therapist may need to own any counter-therapeutic reactivity before asking the client to do so. The purpose of this new, empathetic understanding is to set the stage for new, more rewarding interpersonal behavior grounded in a shift in how self and other are perceived. This shift may require more than cognitive understanding, however empathetic, in both therapists and clients.
Examples of therapists’ efforts to convey empathetic understanding derived from exploration of reactivity show that several elements can be but are not necessarily part of the message: the therapist’s reactivity; the client behavior that triggered the reactivity; the origin and/or function of the client’s interpersonal behavior pattern in therapy; similarity between this pattern and the client’s patterns of interaction outside of therapy; therapist responsiveness to new client behavior whose goal is interpersonal contact; understanding of the difference between self-defeating and contact-promoting behaviors; the possibility of transferring contact-promoting behaviors from therapy to other contexts. In some cases (8, 9) these patterns are explicitly contrasted with clients’ efforts to relate in ways more likely to meet their psychological needs, in part by sharing therapists’ positive reactions to making contact: “I think it certainly would have been about this sort of, her withdrawing, shutting down. And on the other side of the coin, the difference about feeling connected when she did, when it went with a different quality.” In many cases the self-defeating patterns were interpreted as rooted in clients’ interpersonal histories (3, 5, 7, 8, 9). For example, Therapist 5:

So over time he processed those issues and did a lot of focus actually on our relationship together because within or between him and I and in numerous ways it was really a microcosm of went on in his relationships elsewhere, and I think because he respected and valued so much how he saw things that went on between him and I that he could transfer and generalize and see how maybe he was responding to somebody else.

This connection may have been made in other cases in the course of therapy, but it was not explicit in the interviews.

Sometimes being able to use reactivity for understanding helped therapists to be less reactive. Therapist 7 was able to transcend her frustration with her client’s dissociation by translating her reactions into an understanding of her client’s probable dilemma, and then sharing this understanding with her client. Sometimes she described her reactions explicitly: “I am
feeling very deadened, so I am wondering how you are feeling deadened in that you would like to be dead, almost curling up and letting yourself die.” Other times she was guided by her feelings to guess about the client’s experience:

“It seems like you don’t want me to notice. It seems like you don’t want to be seen, you don’t want to be heard. Can you sit with that? What is it like for you to know that you in part create that?” I think it was said much more gently at the time and over long periods of time, and sort of slowly framing it that way for her to see that, to evaluate our relationship as contemporary and present now and how she was repeating the old patterns.

Distinguishing for herself the subjective and objective aspects of her reactivity, and letting go of her need to push for contact, freed Therapist 7 to gently confront her client with her interpersonal dilemma. Therapist 9 used his reactivity in a similar way, foregoing the pleasure of being admired in the process:

I might say things to him like, “Jesus, as pleasing as it might be for me to imagine you think I’m so wise or whatever, I wonder if it might be a lot harder for you to take a good look and see how much that isn’t the case, and how much you need to protect yourself by seeing me that way.”

Therapist 5 had to openly acknowledge the reality of having let his client down before he could address his client’s tendency to feel abandoned and angered by those who misunderstood him. This therapist was cognizant of the fact that his client would not be able to take in any insight about “how he tolerates people or doesn’t tolerate people that he feels don’t listen to him” until the therapist baldly confessed to not listening. When reactivity has already been acted on in the therapy relationship, therapists’ ownership of the subjective side of reactivity seems to make room for their clients to consider the objective side.

One example of sharing reactivity, though it did not have the intended result, was meant to help a family system change dynamics. Once Therapist 4 became more comfortable sharing
his reactivity, he used it to show his client’s mother and stepfather how they might be affecting their son:

   I said a few times that I’m finding myself getting a little defensive, that I’m getting agitated at this, and I’d return it to their son. If he’s in my position, and these are any level of interaction that’s going on, can you imagine what he’s experiencing?

Families present extra variables to consider when managing reactivity and using it to promote insight. Due to the possibility of multiple alliances and identifications, the therapist can easily be triangulated. Empathy for the son can be seen as judgment of the parents, and vice versa. A therapeutic alliance must be developed with all parties, otherwise not everyone is trying to reach the same goal (Johnson & Wright, 2002). These parents seemed unable or unwilling to use the therapist’s reactivity as interpersonal feedback, perhaps in part because the working alliance was too weak.

Therapist 8 was also conscious of the client’s family system and how the therapy relationship might offer a parallel experience. He shared his reactivity to his client’s aloof presentation “both for what it was doing to me, but also as a way perhaps of helping her have a little more understanding and empathy for her husband.”

   In a distinctive approach to conveying understanding, Therapist 1 taught her client tonglen, the therapist’s Tibetan Buddhist technique for transforming a negative reaction into compassion for self and others. This is distinct from all of the other examples in that the client’s new understanding was achieved through an awareness practice rather than direct interpretation by the therapist (although this might also have occurred). Tonglen also goes beyond cognitive understanding to an experiential change. Thus tonglen helped at three levels: Therapist 1 could understand and manage her reactivity; she could understand and respond empathically to her client’s reactivity; and her client could better understand and manage her own reactivity.
Internal Management of Reactivity: Experiential Change

Some therapists went beyond understanding and controlling reactivity in the sense that the felt experience of relationship with self changed. Empathetic understanding of therapist reactivity, already discussed under Internal Management, could also lead therapists to transcend their reactivity and reach a new valuing of self. Not all of the therapists underwent, or at least described, experiential change. Transcendence (versus containment) represents arrival at a different relational position in regards to the personal causes of reactivity. For example, if the therapist’s reactivity is felt as frustration with a client’s avoidant position, rooted partially in fear of being an ineffective therapist, then transcendence might mean accepting one’s human limitations and letting go of fear. In contrast, containment of reactivity would mean setting aside frustration out of recognition that it is not therapeutic, out of an understanding of why the client is avoidant, or both.

It is unclear what factors determine whether a therapist undergoes experiential change. Those therapists who described experiential changes (1, 5, 7, and 12) did seem to describe their personal experiences more openly (in response to fewer cues) and more richly (in more detail, and with more connections to their reactivity) than most of the other therapists. My initial bias was that experiential change signified “deeper” therapeutic work, i.e., work that helped clients experience more lasting characterological change rather than ability to control the tendencies of their characters.

However, it is equally plausible that therapists who did not experience a new relationship to the causes of their reactivity had already done so in their prior personal growth, or had no need to do so because they were already capable of making empathetic, valuing contact with their clients. Another possible explanation for the difference is that therapists who did change their
relationship to the causes of their reactivity chose to discuss clients whose presenting problems powerfully evoked the therapists’ own needs and challenged their usual ways of meeting them. Other therapists may have chosen clients who evoked reactivity that was less powerful for a variety of reasons. A fourth possibility is that the other therapists might have undergone similar experiential changes but not described them, just because the interview process did not lead to them and/or the therapists did not have ready cognitive access to these aspects of reactivity management. These explanations are not mutually exclusive, and regardless of their accuracy, one can still gain clinical wisdom by understanding the experiential changes that were described.

Empathy for Self

The effort to transcend reactivity was characterized by a deepening of empathy for self, or acceptance of reactivity (Therapists 1, 5, 7, 9 and 12). Therapist 1 needed to empathize with herself as a person who had been hurt, Therapists 5, 7 and 9 with themselves as imperfect, wounded beings, and Therapist 12 with her position in life. As discussed earlier, empathy for self differs from (but may accompany) empathetic understanding of one’s reactivity, in that the former represents a corrective experience of self, a change in object relations from an avoidant or rejecting stance toward one’s wounded self, to a healing, accepting stance.

Therapists 1 and 7 described a relationship between accepting and experiencing their own feelings toward their clients, and empathetically experiencing the client’s parallel feelings which the client’s behavior had induced in them. Projective identification, rather than being purely a defense that interfered in therapy, became a vehicle for genuine empathy grounded in the therapist’s own suffering. Therapist 1:

I didn’t need her to stop being hostile. I really reached a point where the hostility would not hit me personally, but would be about her and her pain. I think my own reaction was
adrift because I’m not sure I understood the dynamics of that kind of anger until I really allowed myself to feel it fully as a response to her….

A change in perspective on how the therapist’s humanity (limitations, psychological wounds) is positioned in the therapy relationship allowed some therapists to transcend their reactivity. For Therapist 5, humility was crucial in being genuine with his client and providing a corrective experience. Humility meant “taking more responsibility for times when things don’t well. Instead of looking for reasons, just kind of sucking it in, saying, ‘Yeah the buck stops with me, I made a mistake here.’” For Therapist 7, the necessity for valuing contact with the client was met by a shift in the experience of contact. She moved from a zero-sum model of her interpersonal resources, to a mutually enriching model:

I don’t feel so resentful about sitting here with you and listening to your problems when I have got mine because I know that I can sit here with you and I know that mine will be there, and I know that I am actually going to get filled up. You know that some of this energy that gets going in the intimacy here and the sharing; is it really going to fill me up.

Therapist 7 also came to understand herself as a wounded healer: “…it isn’t about the wound necessarily sealing and healing over completely, but experiencing and knowing that it is there and being aware of it and aware of your own wounding.” Therapist 12 voiced similar thoughts: “I can be…I’m separate from her. And I can be here for her. I don’t have to be completely resolved about all my own issues in order to do that.”

In the context of these interviews, a relational expert is defined as “a therapist who through awareness and acceptance of a client’s psychological wounds and needs and how they play out in the therapy relationship, is able to help the client change ways of relating to self and others.” In contrast, the wounded healer is defined as “a therapist, who through empathetic, valuing contact with his or her own psychological wounds and needs, becomes able to help a psychologically wounded client gain in awareness and acceptance as well, in part through use of
self.” The wounded healer definition seems to apply to Therapists 1, 5, 7, 9, and 12 most strongly, as will be further illustrated in discussing use of self.

Therapist 12 also introduced a unique example of experiential change. For Therapists 1, 5, 7, and 9, acceptance was directed toward vulnerabilities: psychological wounds and imperfection. For Therapist 12 acceptance is directed at the road not taken…the incompleteness of life rather than of the self:

And just looking back and thinking about the choices in my life, the choices I’ve made and where I am in my life, and always coming to terms with that. It’s part of life…and, so that was kind of what was going on in me too [as well as the client]…. These were the choices I’ve made in my life for pretty good reasons. Kind of living within that, learning to accept.

Interpersonal Reactivity Management: Use of Self

Use of self has been defined (Chapter IV) as “the therapist’s deliberate introduction into therapy of any aspect of his or her experience that allows the client to perceive the therapist’s humanity beyond the therapist role.” In the section on internal management a shift from a reactive to a responsive interpersonal stance was described for all of the therapists, while the necessity for experiential change was noted by Therapists 1, 5, 7 and 12. Several therapist behaviors growing out of a responsive stance may be considered examples of use of self: expressing congruent empathy, disclosing psychological woundedness or vulnerability to the client, and making valuing contact. All three expressions of use of self involve therapists’ acceptance of their own and/or their clients’ reactivity.

Use of self is not necessarily dependent on transcending reactivity through experiential change, because some therapists may have already experienced a shift in relationship to self that requires no more than monitoring and containment to be maintained. Such seems to be the case with Therapist 9, who “pushed past the temptation, or the inclination, to get back into a lazy
collusion again and not stay engaged directly.” Rather, use of self seems to occur when therapists have enough trust in their sense of what their clients need versus their own needs to selectively express aspects of their internal experience.

Expressing Congruent Empathy

I could say and mean, “I wish I could be all that you need, I wish I were available 24 hours a day 7 days a week, I wish I had hours and hours to spend with you and I cannot possibly, and I’m sorry.” …I mean that was a compassionate response to her total anger that I refused to be merged with her, be a part of her…

-- Therapist 1

Empathy may be based on the ability to imagine the client’s suffering, care about the client, and express this caring and understanding of the suffering. Empathy may also be reached through awareness of one’s own parallel suffering. This level of empathy includes the therapist’s painful experience – not necessarily described to the client, but held in awareness as the therapist’s side of the resonance. For a client whose psychological wounding includes a violation of basic trust, or a client who simply longs for this deeper level of connection, the therapist apparently needs the capacity for this level of empathy and not be too threatened by it or by the personal history and psychological wound(s) it evokes. When Therapist 1 arrived at this level of empathy she no longer experienced any incongruent feelings, and she believed that her caring came through in a convincing manner.

Therapists 7 and 9 also described how they expressed this level of empathy. Therapist 7 was able to connect to the client’s experience of not being seen, of feeling unloved. In fact her experience of not being responded to by the client evoked the pain of this old wound. This therapist was aware that while her own suffering allowed her to tune in to her client’s experience, she also had to recognize the limits of her empathy and not arrogantly assume she
knew how the client felt. She would make statements like, “I can only imagine how that is, but I can feel it here now and that really does resonate with me and I can feel that within me too.”

Therapist 9 made use of his defensiveness that arose from his client’s projection of shame. This therapist was aware both of how his shame might be a projective identification with the client, and how his shame had roots in his own interpersonal experiences parallel to the client’s:

Probably this would be the most difficult of all, which is that he certainly would remind me of myself in lots of important ways, although he didn’t know that. I could see myself. And I could see, I had the experience of growing up in a family in which there were lots of kids and we weren’t seen very easily, of having a narcissistic mother, of how I used my mouth and my wits and my tongue especially. The devil’s in the details….So, I think my deeper though and overarching point is that I think it’s a challenge personally to work with people who are a lot like us in at least the way we used to be or in the journey we ourselves have made.

Receiving such genuine empathy appeared to help all three clients move beyond a defensive stance, as will be discussed in the next chapter.

Disclosure of Self

In addition to helping clients understand their own reactivity, self-disclosure served two additional functions expressing genuine empathy rooted in therapists’ own suffering, and valuing the client. Vulnerability or limitation could be shared to establish common fallibility (5, 7, 9).

Therapist 9 could make use of the sense of “Gee what I’m experiencing right now as I sit with you…is how I’ll start to, you know, color up and blush and feel like I almost need to get away from being experienced like this, and sort of like, I could feel like the bad me is being put right out there.”
Another type of self-disclosure is of positive feelings toward the client (1, 2, 6, 8, 9), which result from efforts to manage reactivity and come to an appreciation of a challenging client as a fellow human being. Therapist 6:

I felt more vulnerable and more like I wanted to be close to him, more like I wanted to know him, and more like he was much more than just an obnoxious kind of being. So when I opened up little pieces it also felt like I was able to be a little bit more real in terms of my real compassion coming through.

Making Valuing Contact

Once reactivity has been controlled or transcended, therapists can then offer a level of accepting attentiveness that allows clients to explore and accept themselves. Such contact may include the congruent expression of empathy or disclosure of positive feelings, but it can simply mean being open to the client’s experience in the moment, “holding” the client’s experience as several interviewees said. Making valuing contact is distinct from empathy and self-disclosure in that it is not necessarily focused on giving the client a specific reflection of the client’s or the therapist’s experience. Being somewhat intangible, this last dimension of Use of Self is most difficult to describe, and therapists used a variety of terms to denote what appear to be quite similar experiences of relationship to the client. Therapist 1 described how she turned to valuing when she began to feel hostility: “And in the room that’s what I would do, if it started in me, and you know breathe that nice accepting energy towards myself and then to her.” This combination and other similar ones will be examined further on in the context of a general theory of successful reactivity management.

Therapist 8 described a qualitative shift in the therapy relationship that was both result and example of valuing contact: “I think our relationship, the quality of our interaction in the relationship was much more relaxed and much closer and we were able to talk about things that
earlier I had never thought we could have possibly talked about.” Therapist 9 gave an eloquent description of valuing contact that enveloped his own and the client’s resistance to the contact:

I would try to stay engaged by saying, “You know…I think I would rather just try to tolerate being here with you and having you see me as maybe not good enough or not authentic or not whatever, than avoiding the connection.” …I would actually sit a lot closer to him, or right across from him. I might sit on that stool. And we might make some direct eye contact. We might be holding one another’s arms or shoulders or whatever, just so. You know I try to make a lot of use of some active, direct visual and physical connection with the guy, and then I try to make use along with that what I could say is my authentic and genuine valuing of his courage, of his warmth, of his gentleness. I try to really verbally affirm how much that moved me to experience these things about him…push for the experiences that would make for more reciprocal intimacy.

Clients may differ in the quality of valuing contact they need: some may need attention paid more to their strengths, others to their suffering. Therapist 12 also offered contact that emphasized attentiveness to her client’s experience over affirmation of her worth:

In the beginning with her I would get quiet, I would move closer to her and wait until I got eye contact with her, and that would always take awhile. And then I would ask her to just, you know, kind of stay with herself from that. Pay attention to what’s going on. Realize that she is not alone here. That she is being heard. And I’m hearing her.

Although valuing contact does not depend on expressing empathy or making self-disclosures, these uses of self can be combined. Therapist 6 gave an example of valuing contact through self-disclosure:

So I found that I would let little pieces slip out and then I would watch and see if he noticed, which I assumed he would and he did, and what he would make of them. It became a part of what I used to let him know it was okay…that I could tolerate him coming closer….

Therapist 7 expressed empathy in combination with valuing contact, sending the dual message that the client was a worthwhile being undergoing a difficult challenge:

She left feeling pretty lousy, feeling pretty stuck, and I just encouraged her to think ‘You are very brave to let yourself self experience what you have been experiencing, your woundedness. You know, “I am trapped, I am lonely, and I am scared.” You let me see
that and you let yourself sort of sit there with it and identify the other side of it, how scary it is to move to the other side to be seen, how terrifying it also is to be seen.

It is noteworthy that the clients of Therapists 3 and 7 not only suffered from maladaptive interpersonal patterns, but also from severe traumas related to contact that at first prevented virtually any interpersonal connection. These certainly required an almost exclusive focus on the here-and-now, including all three expressions of use of self. At various levels all of the therapists were challenged to bring their vulnerabilities into their work at the same time as their clients threatened these vulnerabilities.

Making valuing contact has an ineffable quality that is evident in how the therapists shifted into a less detached, more passionate mode of discourse when describing such moments in the interviews. Making valuing contact appears to go beyond a technical approach of paying close attention without negative judgment, to an I-Thou encounter (Buber, 1958) in which the therapist is a whole being seeing another being whole, a being whose human suffering and worth are both salient. This experience can be transformative.

Unique Contributions to Theory

One way to preserve the richness of the perspectives shared by the research participants without losing the coherence offered by grounded theory is to identify unique contributions each therapist made to the core process in the theory, therapist reactivity management. These contributions are important not only to a more nuanced, more generative theory, but also to the practicing therapist as possible avenues for reactivity management.

One unique contribution of Therapist 1 was tonglen: the practice of breathing in a painful feeling, and holding it compassionately until the feeling becomes compassion itself, and
breathing it out to one’s self, to one’s client, to the world. *Tonglen* informs the grounded theory of therapist reactivity management because it captures the paradox of turning an absence of love into love, by loving the person experiencing the absence. An in-depth description of *tonglen* and the philosophy behind it is available in Appendix B.

Therapist 2 contributed the knowledge that sometimes reactivity can be a guide to what clients need, rather than merely interfering in therapy. This insight is in keeping with an object relations perspective on therapy, in which the therapist allows the client to pull the therapist into a certain role while maintaining the objectivity needed to monitor when to resist that role and when to comment upon it (Levenson, 1995).

Therapist 3 demonstrated that gentleness can be reactive and unproductive: sometimes a more aggressive approach is needed rather than letting the client’s defenses set the pace. Another insight to be gleaned from this dyad is that the ambiguous nature of therapy, already challenging, can become a source of anxiety for the therapist when a client is unable or unwilling to offer feedback. This is an example of how the inherent risks of being a therapist may combine with client and therapist traits to form reactivity.

The special perspective offered by Therapist 4 and the mother and stepfather of his client is that a vulnerable human response is often better than a carefully crafted therapeutic response, and that any strength with which one becomes overly identified has a shadow side that needs to be integrated into the therapist’s repertoire.

Therapist 5 demonstrated that perfectionism in the therapist can prevent the healing process of experiencing and addressing ruptures in the therapy relationship. Only through responding to his own mistakes was this therapist able to address his client’s core issues in a direct manner.
Therapy dyad 6 informed the reader that theoretical conceptualization of the client can generate reactivity, in that the client only becomes challenging through the therapist’s image of him or her. A change in how the client is perceived also changes the client, through the new ways the therapist interacts.

Therapist 7 described in rich terms what it means to be a wounded healer, and how powerful sharing psychological wounds can be for the client. Also powerful was being with the client in a dilemma rather than trying to push the client past the dilemma: a parallel to accepting one’s own psychological wounds. Therapist 1 described a similar process.

Therapist 8 demonstrated that a therapist could be aware of an interpersonal tendency without necessarily explicitly connecting this with a psychological need. It may be that previously having identified and worked through this need obviated the necessity of making the connection explicit again for management purposes.

Therapist 9 made explicit the central role of shame in preventing an interpersonal connection that would make such shame superfluous. Therapist 9 also demonstrated how parallel introjects in therapist and client can interact to lead therapist and client to collude in avoiding activation of “bad” introjects. Nonverbal or embodied approaches to managing reactivity were introduced – a fitting approach in that much of unconscious communication occurs nonverbally.

Therapist 10 provided insight into how empathy can improve management of reactions in its own right. In other words, setting aside reactivity can facilitate empathy, but empathy can also facilitate setting aside of reactivity. This nonlinear observation also applies to Therapist 12.
Therapist 11 added the possibility that therapist reactivity can be a conduit for important intuition about clients, perhaps by mapping information from past relationships onto the therapy relationship in an intuitive way.

Therapist 12 showed how interpersonal relationships that are safe and valuing can offer the support needed to confront one’s reactivity, because such relationships have been internalized. Therapist 12 also used embodied approaches to becoming present that were self-focused rather than client-focused, such as breathing and feeling the immediate environment. Therapist 12’s reactivity was richly described in its roots in cultural and sociopolitical contexts, demonstrating that reactivity can usefully be traced back generations and located within a context of oppressive societal forces.

These brief descriptions of some of the unique contributions of the different therapists highlight the richness of the clinical wisdom available from a mere twelve hours of dialogue. Therapist stories about their work represent a relatively untapped reservoir of learning for researchers and for each other.

From Reactivity to Responsiveness

The core category of reactivity management encompasses many processes and relationships among processes. Can any central process be described that may prime therapists to move in a certain direction when confronted with their reactivity? Perhaps this central process may be described as *empathetically bringing therapist and client needs into conscious relationship with each other*. This relationship could be *empathic connection* to client needs as resonating with therapist needs, or *empathic containment* of therapist needs to free the therapist to respond to client wounds and needs. These twin psychological movements of connection and
containment are both rooted in empathy. Empathic connection in sentence form might be, “I see you as one like myself, a precious human being suffering from wounds and unmet needs.” Empathic containment might be, “Because you are a precious human being suffering from wounds and unmet needs, I set aside my own needs in order to help you.”

Connection and containment are complementary sides of the coin of interpersonal contact. Contact requires both a boundary between self and other, and a point where self and other meet. This meeting point in the context of therapy is often a felt appreciation of the being of the other, and a felt suffering in connection to the other’s suffering. These aspects of contact emphasize the overlap of self and other; containment emphasizes the boundary between self and other. The therapist recognizes that to act on certain needs would be treating the client not as other, but as an extension of self, a supplier of compensations for unmet needs rather than a subjectively alive being.

The difficulties experienced by Therapist 4 may illustrate the importance of grounding containment and connection in empathy. This therapist did not seem to be able to connect empathically with the client’s parents, who triggered the therapist’s reactivity. Instead, reactivity management consisted of a shift from repression to assertive expression. The therapist was able to connect with his anger in a manner empathetic to himself, allowing him to congruently express it; however this empathy did not seem to extend to the client’s parents. Empathic connection to the other seemed to be reserved for the client himself, with whom the therapist became allied at the expense of the parents. The therapy relationship described by Therapist 4 may therefore represent an incomplete process, aborted by the client’s parents’ impatience and the therapist’s view of the parents as sources of frustration and threat, rather than as beings in their own right.
To return to the more complete process, a closer view shows that empathic connection and containment can facilitate each other. Containment of needs makes room for empathy, and empathy motivates therapists to contain their own needs. Therapist 12 put it: “…so it’s probably more just a circle overall that I do work with myself more outside the session I guess. And, then I’m more settled and able to empathize more and that makes it easier to contain….”

One might view the ideal cognitive-emotional position of the therapist as poised at the meeting point of self and other, thinking and feeling into what the client experiences, while simultaneously looking backward into one’s self for thoughts and feelings in response to the client’s experience. Attention to the client and to the self also has a temporal dimension, at times ranging back to the roots of the current experience, at times looking forward to further development, as with Therapist 9, who pushed “for the experiences that would make for more reciprocal intimacy.”

Therapists whose reactivity is provoked but successfully managed are both pulled by purpose – their clients’ development and perhaps their own – and pushed by pain, the pain of their own and their clients’ unmet needs or wounds seeking a new level of resolution. Thus therapists who shift from reactivity to responsiveness bring their psychological needs and their client’s psychological needs into conscious relationship in the present moment of contact, at the intersection of their separate developmental paths. Both may end up traveling further along paths of development as a result of the interpersonal challenge of being with each other. Such development is the subject of the next chapter.
Chapter VIII

RESULTS OF REACTIVITY MANAGEMENT AND USE

Within the last couple of sessions before she left, she said this is the first place she’s ever felt safe. She gave me that. And she said, “I’m going to miss you, and I don’t think I’ve ever said that to anyone in my life.”

-- Therapist 3

And these clients certainly have been the most powerful tests and teachers.

-- Therapist 3

Introduction

In this chapter the range of client responses to therapists’ management and use of their reactivity will be described, along with therapists’ personal and professional development resulting from their engagement with their reactivity. Both client responses and therapist development appeared to diverge depending on whether their therapists underwent experiential change in the process of managing their reactivity.

While understanding and even transcending reactivity to clients can be a developmental experience for therapists, the overarching purpose that guides such efforts as well as guiding this research, is to help clients develop along the lines of their individual therapies. Therapists nominated for this study were asked to choose clients who seemed to have benefited from the therapists’ management and use of their reactivity. Although one client had not yet completed her therapy, and the family therapy was aborted, all of the therapists perceived important positive outcomes to their engagement with their reactivity.
The key ideas relevant to results of reactivity management are:

1. Therapists’ empathy for self and client helps clients who have experienced a lack of acceptance to attain a corrective experience of relationship.

2. Therapists who provide valuing contact when they disclose reactions they have to their clients, while also demonstrating empathetic understanding, help these clients to make valuing contact with themselves and others.

3. Clients who have a corrective experience through their therapists’ empathy, valuing contact, and/or empathetic understanding may gain the ability to offer themselves the same.

4. Clients who have a corrective experience through their therapists’ empathy and/or, valuing contact may gain in their ability to offer and experience valuing contact in other relationships.

5. Clients who gain in their ability to offer and experience valuing contact may experience reduced cognitive and emotional symptoms and/or improved daily functioning.

6. Therapists who manage their reactivity successfully may develop a greater capacity for valuing contact with self and others, as well as greater acceptance of life.

Client developmental changes as a result of therapist reactivity management and use included: initial defensive reactions to the possibility of more emotionally intimate contact; impasse resolution; corrective experience of relationship; exploration of previously untouched areas; emotional release, development of sense of self; new understanding of self and relationship; improved emotion management and decreased subjective distress and symptoms of mental health disorder; and improved functioning in social contexts.

In the family therapy case, the parents pulled out because they were locked in their reactivity; however, the therapist’s shift toward greater congruence appeared to calm the clients enough to avoid further escalation and possible litigation. In all other cases either the reactivity was avoided in favor of meeting the client’s therapy needs, or the therapy relationship was
transformed from mutual reactivity to a corrective experience. In one of these cases (Therapist 7), the therapy relationship was not complete and symptom improvement could not yet be observed, but an impasse was resolved. In all other cases some improvement of functioning and/or reduction of symptoms (i.e. depression, anxiety, lability, dissociation) was observed. In one of these cases, termination was required because the client needed a higher level of care; while self-management had improved, the biological expression of the illness had worsened. In all other cases, termination was agreed upon as a result of meeting therapy goals.

Results of reactivity management generally evolved over time in combination with therapeutic interventions. Some of the therapists (1, 4, 12) noted that technically correct interventions were impotent before they were accompanied by a shift in the therapists’ experiences of themselves, their clients, and/or the therapy relationship, e.g. Therapist 12 doing “work that wasn’t very effective with her, because she didn’t feel really seen and heard.” Some clients also underwent not entirely smooth adjustments as their therapists approached them in new ways.

The Threat of Valuing Contact

Two therapists (1 and 9) mentioned initially avoidant reactions by their clients to valuing contact offered by the therapist; this is not surprising in that ambivalence about contact or emotional intimacy is often a theme of therapy, and according to these therapists was a central dilemma for their clients. These negative reactions expressed themselves in various forms of deflection of contact. Therapist 1 noted that an empathetic response placed her client in unfamiliar territory:

I mean she would later say to me, “How can you handle my rage? How come you’re not angry when everyone’s angry at me?” And there was a piece of her angry that she wasn’t
getting the anger. She knew how to handle the anger, she had a defense with the anger, and she felt quite vulnerable.

This client threatened termination when the therapist genuinely expressed regret at having limits on the therapy relationship. The therapist interpreted this reaction differently from the client’s previous anger at having limits set, because here the client seemed more threatened by the therapist’s compassion.

Therapist 9 described how his client reacted to valuing contact: “As he did put his stuff away and began to look at me, he began to become very, very anxious. Fidgeted, moved around, changed the subject, all kinds of things to break the contact in some ways.” Therapist 9 also identified reasons that he believed his client was threatened by valuing contact. “So he could hardly tolerate the gaze, so to speak because of the evil eye. A rejecting, hateful, judging, critical eye or whatever you call it.” His client also seemed to fear being engulfed due to unclear boundaries. Both expectations appeared to originate in the client’s relationship with his mother.

These examples point out that when therapists are able to transcend their own ambivalence about making more powerful contact with their clients, they must still be sensitive to their clients’ reactions. Therapist 1 took the approach of maintaining her genuinely empathetic position, so that her client came to trust it; Therapists 9 worked with his client’s difficulty with contact by expressing his own shame, thus raising their mutual ambivalence to an explicit level, helping them to paradoxically be with each other in their fear of being with each other.

Therapy Relationship Development

The therapy relationship often moved beyond an impasse when the therapist was able to shift from reactivity to responsiveness; at times the resolution of an impasse also represented a corrective experience for the client (1, 3, 7, 12). Corrective experiences teach that not all
relationships need be patterned after the painful past, that the relationship or interaction with the therapist represents the possibility of other ways of interacting or other responses. Corrective experiences may also help clients internalize a more empathetic view of themselves, as they see it reflected in how they are perceived and treated by their therapist.

Therapists 1, 3, 7 and 12 identified safety as the key theme of their clients’ corrective experiences, because formative relationships had been abusive or neglectful. Therapist 1 gave a poignant example:

I think she could stop being so afraid of her own sense that there was nothing she could do to stop the hurt of not being seen by people…her feelings, her anger, to just stand there… stay there, and hear her and accept her and not be angry back.

The safety of the therapy relationship also allowed some clients to “hold” painful experiences while being “held” by the therapist (1, 3, 6, 8). This nesting effect may be internalized such that the client can take the same compassionate stance toward self that the therapist does. Therapist 1 observed about her client that “eventually over fifty percent of the time she could meet her own feelings with compassion.” For a client with borderline personality organization, this change was crucial in reducing the need to project the rejected self into others. Therapist 3 found that once she shared the dilemma her client’s dissociation presented, her client “was able to respond to that real clearly; she said, ‘I want you to move in.’” From then on Therapist 3 was more persistent and her client was able to make more contact, both with her own pain and with her therapist.

One aspect of emotional intimacy was being able to talk about problems, feelings, and relationships. Therapist 8 described the corrective experience of intimacy in terms of both the feeling and the content of conversation:

There was a difference in both of us, and there was a difference in the quality of the interaction in the relationship. I mean, it became much more intimate in some way….
mean I think we did look, I think there was a shift to focus more on her difficulties in shutting herself off. . . . In terms of issues around loss and her family avoiding things, the whole clear kind of piece there that you don’t talk about these things was challenged more than talked about with her in the relationship.

To Therapist 6, the emotional intimacy of the therapy relationship both offered that experience and provided a safe place to talk about vulnerabilities: “It helped to shift him to where he could say ‘I am missing something,’ which is a huge step for him and also for us.” Therapist 6 described how large a step it was for her client to express his human needs:

> It was like looking at a very frightened animal. You knew that it took all of his courage just to put this out there and hope that something bad wasn’t going to happen, but he would say, “You know you have treated me more like a human than anybody else.”

Another nuance to emotional intimacy being safe is learning that it can withstand challenges. Therapist 5 learned, and in the process helped his client learn, that emotionally intimate connections could be resilient. The client could

> …realize that much like before, when people aren’t paying attention to him he equates that with them not caring about him. And he was able to look at that with me and see that I care about him a great deal.

Therapist 7 spoke in a similar manner about clients learning that her attunement to them would come in waves. Taken together, these different facets of safe intimacy paint a portrait including the elements of validation, safety from harm, open communication, and tolerance of imperfection.

When therapists embodied the wounded healer (1, 5, 7, 9, 12) by experiencing or sharing their vulnerabilities and imperfections as part of their sensitivity and acceptance, were changes in the therapy relationship different? Perhaps those clients who had great difficulty trusting that they could be understood in their own psychological wounds or responded to as another imperfect human being, most needed their therapists to be wounded healers rather than relational
experts. The question of what degree of self-disclosure was needed for different clients to develop a sense of safety is not answered by this study. However, from the point of view of these therapists, connecting as suffering, worthy human beings was crucial in working through mutual reactivity to a corrective experience for their clients. Therapist 7:

She did something that felt very different: came in, sat on the floor and usually if you are there and I would kind of like (this would be the couch that we sit up against); she would be like this and I would be like this [Therapist 7 indicates that they sit on the floor next to each other]. She came in and sat down here and looked right at me you know and so it was very kinesthetic; I could feel the shift in that she doesn’t make a lot of eye contact. It is very scary for her to do that and it was just…she was just there. It was amazing.

Client Emotional Release

Once the corrective experience of safe emotional intimacy developed, the contrast with past interpersonal experience could trigger ambivalence in the client, as with the clients of Therapists 1 and 9, but could also provoke previously unexpressed emotion, especially due to the relative safety of the therapy relationship. Several therapists (3, 5, 7, 9) observed that as a result of having confronted or managed their own reactivity, they were able to engage clients’ own reactivity in ways that allowed clients to express emotions that had been suppressed. These emotions related to loss of contact or wounding contact with important people in their lives.

Once Therapist 3 acknowledged her dilemma about approaching her client when she was dissociating, her client was able to unleash rage toward her therapist that had not been safe to express to her mother about ignoring her and her victimization. This rage energized the therapy relationship and lead to greater contact. Therapist 9 also identified unexpressed anger as a theme, imagining his client’s thoughts:

“How can it happen that I can be seen as good enough, okay and lovable, and yet I didn’t get that from the ones whose job it was?” …I think that’s about the central pain of it and... it’s not just, it is profound grieving, but also that I think it stirs up a whole other
dimension of anger too. And that’s so important, I think that’s what with this man and I had to work with, because the anger that leads to engagement is so central.

Client Development of Sense of Self

Another theme of corrective experiences is the freedom to differentiate and even separate from the therapist, not only in terms of termination, but in terms of autonomy within the therapy relationship. Therapist 9 described this differentiation as “his ability to say very much how he was not me, I was not him. I was different than he.” This experience was corrective of the client’s enmeshment with his mother, who met expressions of individuality with a critical eye. Therapist 11 did not describe her client’s early interpersonal history other than to say that her pattern was to be dependent and fused with another person (hence her intense abandonment depression when her relationship ended) yet conflicted about clearly expressing needs. Therefore therapy became a corrective experience of collaboration, in which the therapist helped the client help herself:

I don’t think it’s in the client’s best interest to give the answers and, that’s just my philosophy about therapy, and so I would not do it and it became a joke between us, you know. She’d say, “I know you’re not going to answer this, but....” You know, like, “Don’t tell me this, don’t answer it by saying ‘What do you think?’”

Therapist 2 supported his client in developing an adult identity as a capable young woman, by maintaining his boundaries to the extent that he did not simply become a substitute father and encourage ongoing dependency. This was not so much a corrective experience as a developmental one.

For the client, new understanding that is induced during the therapy session takes place in a relationship and may be a different relational experience than the client’s usual one. For example, by attentively teaching the client how to be compassionate with self, Therapist 1 was
concurrently telling the client, “I care about you enough to help you relieve your suffering” and “I understand the nature of your suffering.” All of these corrective experiences could be viewed as examples of a holding environment: one in which the client could safely develop, whether this development was in the areas of competence, identity, or intimacy. This holding environment also allowed in some cases a dual new understanding/corrective experience, as awareness increased regarding defensive patterns of relationship to self and others (Clients 5, 6, 7, 8, 10, 12). This result is also implied by context for Clients 1, 3, 9, and 11. In other cases, (Client 2) a defensive pattern was not the focus of therapy or (Client 4) the client’s parents did not take responsibility for this pattern as it played out with the therapist and with their son, the client.

Client Understanding of Self and Relationship

Some of the therapists described insights clients were able to reach about themselves as a result of examining the therapy relationship together (1, 2, 3, 5, 6, 8, 9, 10, 11, 12). Insights varied widely in content, often being connections among elements of client reactivity, such as origins, current functions, current drawbacks, and parallels between therapy and other relationships. Client 1 was able to take ownership of her rage at feeling invisible to others and how by defensively pushing them away she made it difficult for them to see her as a suffering, worthy person. Client 2 understood how she was compensating for the loss of her father through her therapist, and was able to see her increasing independence in making decisions in the context of moving from a daughter role to an adult role. Client 3 understood “that her rage was about the feeling…like a replication of her mom, who is always helpless, and incompetent, as a mom. And also, who she believes actually knew about the abuse and did nothing.” Client 5 realized that
people who disappoint you can still care about you, and that rifts can be mended. His ability to gain these insights resulted from the fact that

In numerous ways [the therapy relationship] was really a microcosm of went on in his relationships elsewhere, and I think because he respected and valued so much how he saw things that went on between him and I...he could transfer and generalize and see how maybe he was responding to somebody else.

Client 6 became aware of his profound lack of relationship to others and his desire, however frightened he was, to be in relationship. He could only acknowledge this very gradually and as a result of his therapist’s genuine empathy for him. Through a gradually more emotionally intimate interaction with her therapist, Client 8 saw the connection between greater emotional openness and more rewarding relationships, as well as the origin of her guarded stance in her family of origin. Client 9 became aware of his defenses against contact as well as their origins, of his negative self-concept that he had introjected from his mother, and of his tendency to project that introject onto others. Client 10, by knowing that she was accepted by her therapist, was able to own her tendency to be off-putting and seek coaching on how to be different. Therapist 11 found that her refusal to give answers “sort of was a way for us to look at her need to be rescued and her need to be needed, you know and how those kind of played out in her life.” Therapist 12 had to come to terms with her own choices and their attendant losses before she could help her client get “closer to being able to really embrace her own choices and not feel like she had been, you know, conscripted into slavery or something.”

Themes of clients’ empathetic understanding of themselves arrived at through their therapists’ use of self or use of reactivity were: the expression of their reactivity in the therapy relationship; origins, function, and existence of their reactive tendencies; reframing of experiences previously viewed as limiting; and ways to experience relationship as more
rewarding. These themes reflect similar understandings reached by therapists about themselves in exploring their own reactivity (see Internal Management). These similarities are not surprising given that both therapists and clients are human. Next I turn to ways in which this understanding was applied by clients to improving their social and emotional functioning.

Client Improvement in Social, Emotional, and Daily Functioning

How do changes in the therapy relationship or the client’s functioning within that relationship carry over into the client’s life? Without exception those therapists who described improved management of emotions and/or symptoms of mental health disorder (1, 3, 8, 9, 11, 12) traced these changes back to corrective experiences of relationship. Therapist 9 gave the most complete description:

To the extent this man really reconnected with his own vital self, there certainly was a relief of the depression as a whole. So I think that would be one of the outcomes that… I think his anxiety reduced, because his anxiety was so much about being, being seen, and being known, and having the courage to be expressive of who he actually was…without fear of being judged as bad or not good enough.

Therapist 3 observed that in spite of not working much directly on symptom management, her client “really came out of what I see as chronic, chronic PTSD. Again to feel like an adult operating in the world, more and more of the time. She could clearly label when she was feeling like a child, a lost child, into feeling like a functioning adult.” The therapist attributed these improvements to her client’s increased ability to tolerate emotionally charged material within the safety of the therapy relationship, which in turn resulted in part from the therapist’s shift in pushing to maintain contact. Therapist 8 noted a similar connection, between his client’s reduction of anxiety and her corrective experience of being able to talk openly about emotional and sexual issues. Therapist 1 described how the biological aspect of her client’s mental health
disorder became more difficult to manage due to problems with medication, yet her client was able to tolerate psychotic symptoms by using tonglen, in other words exercising acceptance toward herself and her experience. Therapist 12 connected her ability to develop a soothing, containing presence to her client’s “ability to maintain, to contain herself, to manage her emotions. To really self-soothe and in the sessions to listen to more than a sentence of what [her husband] was saying.”

How did improvements in emotion management have an impact on social functioning? Therapist 12 observed that her client’s ability to self-soothe was maintained outside of couples therapy: “She’s not acting out at home. She’s not screaming and having these raging battles with him. And she’s able to really look at her own stuff, that she could never do until he was able to, so he could acknowledge his stuff.” Clients 8 and 9 also experienced improvements in their marriages, related to their increased capacity for emotional intimacy. Client 1 was able to volunteer at her church and develop supportive relationships at a partial hospitalization program, as a direct result of learning to give others the opportunity to know her. Therapist 1 believed that her client was able to move past her hopeless position with anger by observing her therapist transform her own response to anger: “I cannot help but think that her ability to work and change something about herself also came…. I believe she experienced my change.”

For some clients, social functioning improved in tandem with emotion management, and both resulted from a supportive yet challenging relationship with their therapists. Therapist 2 stated that “a lot of our work revolved around her…demonstrating to herself her ability to kind of master her environment now as a solo act in the world.” Therapist 11 identified a similar type of progress connected to exploration of the client’s dependency and corrective experience of being helped to help herself: “she is taking a lot more of her own initiative to set limits around the
neediness and to look more for what she needs, and taking space for herself and making her needs known.”

Overview of Client Development

What are the connections among the holding environment, corrective experience, self-understanding, social and emotional management, and termination? One coherent explanation corresponding to the data might be: As possibilities for self-relating and other-relating that are emotionally charged are opened up that do not prove catastrophic inside and outside of therapy, the client’s associated anxiety and/or depression tends to decrease. The capacity for making and accepting decisions regarding needs, relationships, and life choices tends to expand as fear or hopelessness is reduced, such that overall functioning is enhanced and therapy is no longer needed.

Therapist Development

Both clients and therapists appeared to undergo significant changes as a result of therapists’ efforts to bring their own and clients’ psychological needs into some relationship with each other. Therapists tended to develop in their personal and their professional awareness and functioning, in ways that sometimes overlapped. Professional development occurred in three ways: increased sensitivity to or empathy for clients (1, 4, 6, 10); positive changes in self-evaluation (3, 5, 7); and a shift in approach to client anger (1, 3). Personal development also fell into several dimensions: decreased defensiveness (4, 5); increased acceptance of life (12); deepened experience of emotion (3, 7); and increased assertiveness (1). Other therapists did not identify specific forms of development.
Increased sensitivity to clients and their feelings included some particular areas relevant to clients’ presenting problems. Therapist 1 felt she developed in her ability to connect and work with people diagnosed with Borderline Personality Disorder, while Therapist 6 stated, “I now have a deep, experiential appreciation for the schizoid complex and their often unrecognized need for relationship.” Therapist 4 developed a greater appreciation for family systems versus focusing strictly on the child.

Broader changes were described by Therapists 1 and 10. Therapist 10 observed that “With each such experience my capacity for empathy increases and judgments of others seem to decrease.” Therapist 1 noted that she became more sensitive to subtle reactions to clients, and more willing to explore them. She also described how “whether or not I’m aware that the person has the feeling, in tonglen I will imagine and give it to them, because it brings an understanding of them that I’m not getting in the room.”

Two therapists described increased tendency to use their reactivity to help clients. Therapist 4 arrived at a new understanding of how awareness of own emotions could assist him in understanding and helping clients:

I find myself focusing more on my under-reactivity and finding ways to not be so under-reactive in certain situations…. I look at, okay I’m calm but I’m having a reaction to this, I need to find a way to process this and explain it to the client. Not necessarily my reaction but what I’m reacting to, and not letting my reaction cause me to go in a direction in therapy I don’t want to go, which could be more of an avoidance on my part because I don’t want to push this button or that button.

In keeping with her understanding of the connection between compassion for self and other, Therapist 1 also emphasized how her awareness of her reactivity deepened experientially:

And [tonglen] truly taught me as a therapist to really, really own reactions and to allow myself to move fully in them. That’s what that tonglen practice does is it gives you…you really feel the feelings that you’re feeling.
Therapists 1 identified the power of holding feelings when they seem overwhelming. She described this paradox: “I realized that when you feel powerless, that here is a way of just accepting and holding what’s bringing up the powerlessness.” Working with this client was for Therapist 1 a real watershed: “I would say you know that she has been pivotal for me in deepening what I can do with people that I cannot imagine a way through in a cognitive sense.”

Through confrontation with interpersonal dilemmas, several therapists mentioned that they developed different views of themselves as therapists. Therapists 3 and 7 developed greater confidence in their clinical instincts and ability to cope with challenging clients. Therapist 7 found confirmation of her unique approach:

Finding aliveness in there and letting myself be different than what I think other people may be doing you know in psychotherapy….because our training is very much you know a blank slate and the therapy that I do a lot with clients does involve touch.

Therapist 5 became less perfectionistic and understood mistakes in a new way: “That day I found out that it [a therapist mistake] doesn’t just rupture the relationship….You know it’s not whether you make mistakes, it’s what you do with it afterwards.”

Personal development of therapists sometimes reflected professional changes. These ranged from awareness of emotion, to emotion management, to transcendence. Of her client, Therapist 7 said, “I definitely think that she was somebody who, one person who allowed me to contact that space [of psychological wounding] more and touch my own sadness and my own anger and rage.” Therapist 1 became both “less reactive in the world” and better able to “stand with anger.” Thus she took ownership of her emotional experience and acted at its prompting in more intentional ways.

Therapists 5 and 12 saw themselves as transcending reactivity to reach a more accepting stance. Therapist 5 found that the same lesson applied in and out of the therapy room: “One good
outcome of all of that is I’m complete with others in my life, that I’m much more able to drop that defensiveness, not just in therapy but elsewhere too. There’s really no need for it with a lot of clients.” Therapist 12 found her desire to reach a new orientation to life furthered:

It’s very helpful to say, “Oh, there’s that again.” And that is this feeling of, you know, wishing to be taken care of, wishing that I could just lean back and have somebody come in and clean my house and do all this other stuff. And just looking back and thinking about the choices in my life, the choices I’ve made and where I am in my life and always coming to terms with that. It’s part of life.

Conclusion

Client and therapist development reflect corrective experiences of self, relationship, emotion, and life. Clients were often able to generalize from corrective therapeutic relationships to important personal relationships, including with themselves. Such changes argue for the importance of engaging one’s own and one’s client’s reactivity in an accepting, curious manner. One’s natural reaction to threats, internal or external, is to control or avoid them, rather than embrace them as guides to deep feeling and transformation. These therapists have demonstrated that the degree to which one embraces one’s human experience or the experience of a client, no matter how painful, is the degree to which one can help one’s self and the client to take the risks of living more authentically. Symptoms like anxiety, depression, and dissociation are then replaced with feelings of anger, sadness, compassion, and acceptance: feelings that connect us with life and each other.
Chapter IX

INTEGRATION OF GROUNDED THEORY
WITH EXISTING THEORY AND RESEARCH

Introduction

The grounded theory of therapist reactivity management presented here offers a fertile ground for exploring conceptual relationships and generating hypotheses for future research. This chapter presents a comparison and integration of the grounded theory with the theoretical claims and empirically supported hypotheses reviewed in Chapter II. The purpose is not to validate findings through convergent results; when comparing grounded theory with quantitative research or theory developed less systematically, there can be no way to determine if constructs are equivalent. Conversely, convergence between grounded and ungrounded theory could result from research participants, the investigator, and psychodynamic/object relations theorists all sharing a broad theoretical framework they impose on their experience. However, the coherence of the integration presented here may suggest that the grounded theory may be generative of further theory-building as well as insight and choice in particular clinical situations.

To begin, some general comments are made comparing the grounded theory to overviews of theory and research. An integration of the following areas across the grounded theory and the literature is achieved through the transcendent/embedded dialectic identified by Coburn (1999): the nature of therapist reactivity and its relationship to client reactivity; therapist traits and attitudes that facilitate reactivity management; the intrapsychic process of reactivity management; and use of reactivity in the therapy relationship. Application of this synthesis to an expansion of the tripartite model of the therapy relationship (Gelso & Carter, 1985, 1994) helps
to place reactivity management in the broader context of the therapy relationship as a whole structure and process. The synthesis of these ideas also lays the groundwork for a reconsideration of the nature of intersubjectivity at the chapter’s end.

**Strengths and Limitations of Three Approaches to Theory Development**

Unsystematic theoretical exploration, quantitative research, and grounded theory and its qualitative relatives, each represent a different approach to theory development with unique strengths and limitations. The unsystematic approach may be the least trustworthy in its inferences, but it also provides unparalleled depth of thinking. Quantitative research is the only method of developing a network of tested relationships among constructs (although the relationships between the constructs and the clinical experiences they are meant to represent must remain indeterminate). Grounded theory and its cousins allow one to be relatively more exhaustive in searching out possible constructs and relationships among them, while at the same time offering theoretical coherence that neither of the other two approaches can emulate.

Research on countertransference management has largely asked the question, “What therapist traits are related to reductions in behavior associated with countertransference?” Some research also asked, “Do reductions in such behavior have a positive impact on clinical outcome?” Research design limitations have often left the actual connection of behavior to countertransference origins uncertain, as well as the mechanisms through which traits like empathic or theoretical ability are expressed in therapeutic behavior. The grounded theory makes such connections explicit, although it leaves unknown whether these connections exist in some measurable sense, or are post hoc explanations the therapists and the investigator have imposed.
Unsystematic theoretical exploration has yielded a rich depth of understanding of constructs like subjective and objective aspects of countertransference, narcissistic wounding, shame, anxiety, projective identification and other defenses, empathy, concordant and complementary identification, repetition and corrective experience, transcendent and embedded perspectives on subjective experience, integration of affective and cognitive responses, and intersubjectivity. This depth can easily be integrated with grounded theory to the extent that the same constructs are relevant to the participating therapists’ experiences. However, whenever a theorist tends toward reductionistic assumptions (countertransference is always a result of unconscious needs, therapists should only disclose their subjective reactions under certain conditions) then grounded theory offers evidence of a broader range of experience.

Therapist Reactivity

In the grounded theory, the concept of unmet psychological needs is central to understanding the source and action of therapist reactivity. These needs fall essentially into two related categories: those involving the self’s relationship with the self, and those involving the self’s relationship with others. In terms of relating to the self, therapists’ need for a positive self-concept was threatened by client behavior and/or the therapists’ reactions to that behavior. In terms of relationship with others, the concept of unfinished business was used to denote unresolved feelings about past interpersonal relationships, while interpersonal needs referred to present needs frustrated by the client. These two causes of reactivity often converged.

Psychoanalytic literature and in particular the intersubjective view of the therapy relationship suggest that empathic failures from childhood are the common root of unmet needs in both clients and therapists (e.g., Coburn, 1998; Hahn, 2000). However, the range of issues
described by the research participants includes but goes beyond empathic failures. While some therapists identified such sources in their clients, and of these, some identified related needs within themselves, the rest uncovered other sources, such as loss of an affirming relationship, cultural expression of anger, family roles, and socioeconomic realities. To reduce all possible threats to a single, albeit important one, is to fetter the practicing therapist’s imagination in identifying reactivity, and put theory ahead of experience.

The manner in which such needs play out in the therapy relationship is also more differentiated within the grounded theory. One construct located within the intersubjective literature but not spelled out in the grounded theory is unconscious communication of needs (Coburn, 1998). In the intersubjective model presented in Chapter II (Figure 1, p. 36), this is the linchpin for mutual reactivity. Mutual, unconscious communication occurs below the radar of explicit verbal interchange. Therapist and client needs are held to be unconscious; those needs that are least acceptable to the client are most likely to be communicated unconsciously, and therefore to go undetected and uninterpreted by the therapist. If uninterpreted, such needs are likely to trigger therapist reactivity rather than be available for conscious scrutiny and engagement. The same is true of the unconscious needs of the therapist.

In theory this all makes sense, and in fact many of the therapists interviewed for the study noticed non-verbal or paraverbal expressions of emotion that triggered their reactivity. However, in many cases clients were quite aware of the need or accompanying emotion being expressed. When emotion was itself considered dangerous by the client, the therapist had to be alert for emotions that were elicited rather than expressed, for example through projective identification (to be discussed below). The therapists themselves became conscious at different points in the process of their own needs that were triggered by clients; these needs may have been expressed
unconsciously as a blurring of boundaries around termination, avoidance of certain topics, or lack of genuine empathy. In other cases therapist needs were clear but could not be engaged successfully at first in a way that broke through impasses with clients.

These examples do not add up to an argument for unconscious communication of needs on both sides being a necessary element in mutual reactivity. Needs can be conscious and still trigger reactivity in the person toward whom such needs are directed. In some cases clients were quite direct with their therapists, who still felt the desire to gratify wishes, distance themselves, or be punitive. Therapists can be aware of their own needs and still be reactive to them. Consciousness is not the totality of reactivity management, just as insight is not the totality of therapy.

Coburn (1999) states that mutual narcissistic wounding may occur as each partner in the therapy relationship attempts to self-regulate in response to the other. Shame is the frequent outcome as well as source of such narcissistic wounding. Shame may be a response to projection or projective identification on the client’s part, when the therapist is pushed to take on the “bad” self, i.e. qualities the client rejects as “not me.” This shame response also has roots in the therapist’s own sense of internal badness; without this, shame projected by the client would find nowhere to stick. This mutual wounding is described in several therapy dyads, although shame is not always an explicit factor.

Hahn (2000) identifies four defensive responses therapists may have to their own shame: withdrawal, avoidance of the topic, caretaking, and attacking either self or client. These responses closely parallel the triad described in the grounded theory: avoidance, approach, and aggression. What becomes clear through object relations theory is that shame may be a more primary experience than anxiety. Although anxiety may be the first response to a threat to self,
shame may precede the anxiety as a basic position that is activated by a specific threat. Shame is often unconscious, because it threatens us with awareness of that which we do not accept in ourselves.

Identifications are one way in which therapists find themselves embedded in the intersubjective field with their clients. One way to understand the range of reactivity and its management in the grounded theory is to observe each therapy relationship in the context of concordant or complementary reactivity (Racker, 1957). Some therapists identified with their clients (concordant) and some identified with their clients’ parents or child (complementary).

Racker (1957) appears to have ignored the potential interference in therapy of concordant identifications, instead equating these with empathy. Reich (1960) described empathy as relying upon “trial identifications” that the therapist should engage in without losing an observer stance; Racker, too, emphasized the importance of both experiencing and observing reactivity (countertransference) rather than either denying and repressing or acting out. However, Racker, unlike Reich and unlike the research participants who had concordant reactions, did not see any special need to observe and interpret concordant reactions as manifestations of subjective reactivity. The grounded theory makes this need explicit, and identifies therapists’ resistance to awareness of their own suffering parallel with the client’s as a factor interfering in therapeutic engagement.

Management Facilitators

Beyond a flexible approach to transcendent and embedded epistemological positions, and a general openness to self-awareness, theorists have demonstrated more interest in reactivity management processes than facilitators. In this area research has more to say, and here those
factors that have received some empirical support are compared and integrated with the grounded theory.

**Empathic Ability, Therapeutic Attitudes and Theoretical Ability**

Empathy is explicitly described as an important means of and/or result of managing reactivity with ten of the twelve therapists. Empathy can allow the therapist to view client behavior that would otherwise seem unacceptable as understandable. Empathy may override a defensive distancing, controlling, or attacking reaction in the therapist. In the research, negative relationships were discovered between empathy on the one hand and countertransference behavior and feelings on the other. Empathy was also positively correlated with openness to countertransference, a variable which gauged therapists’ willingness to notice and value their reactivity. Empathic ability as one of the factors in the Countertransference Factors Inventory (CFI) was not related to any process or outcome involving countertransference; however, the absence of such a relationship could possibly be attributed to problems with the measure or the research design.

Empathy is a complex construct in that it typically involves both affective and cognitive components. It may also vary in its depth, being either the effort to imagine one’s self into the subjective world of the client, or resonance with that world through the investment of private meanings (Spence, 1982). Given all these dimensions, therapists still seem to know when they are deficiently empathetic with a client, enough to wonder about themselves if they are predisposed to do so. Inconsistencies in the research in how empathy is understood and expressed may be less important than the overall importance most of these therapists attach to empathy.
In two analogue studies, openness to countertransference feelings was negatively related to countertransference behavior, when combined with theoretical ability (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). The variable of openness is a composite score based on three questions regarding the frequency, importance, and occurrence during sessions of countertransference. Such openness corresponds to the grounded theory notion of positive therapist attitudes and beliefs regarding reactivity, as well as the trait of being non-defensive. Five of the therapists explicitly discussed such attitudes or traits, and the remaining seven implied the need for openness in describing how they did allow themselves to become aware of their reactivity. On its face, such an open attitude would seem to be a powerful factor in becoming aware of reactivity, yet a number of therapists who saw themselves as open struggled with their resistance to greater self-awareness. Perhaps the willingness to engage in such a struggle at all indicates openness.

There were examples of theory being unhelpful when it was not accompanied by openness: Therapist 1 coming up with technically correct interventions that effectively rejected the client; Therapist 3 respecting the client’s space to the point of perceived abandonment; Therapist 4’s belief in the importance of calm under fire. At the same time, theory could be extremely useful in reconceptualizing the client and the work of therapy, as with Therapist 6 (the schizoid personality) and Therapist 12 (the concept of differentiation in relationships). These concepts were activated by awareness of disturbance of contact with the client. Theory can be used to justify one’s current course of action, or question and redirect. Questioning is generally not a defensive manoeuver, although staying the course isn’t necessarily defensive either. The difference seems to lie in the motivation: to avoid pain, or to promote development.
Openness to countertransference feelings, positively related to empathic ability in one study (Peabody & Gelso, 1982), seems to provide a mirror image of the empathy process, with self replacing other as the object of one’s compassionate understanding. This mirroring is borne out in the parallel experiences of a number of therapists who, once they were able to identify and accept their own reactivity, became able to attend more empathetically to their clients’ experiences.

**Self-Integration**

One of the factors in the Countertransference Factors Inventory (CFI) used in several field studies may have implications for the grounded theory. Self-integration was negatively related to countertransference behavior, which in turn was negatively related to positive therapy outcome in one study (Hayes, Riker & Ingram, 1997). The self-integration factor attempted to capture two related therapist traits: wholeness or balance, and healthy boundaries. The first part of the construct does not have any close parallel in the grounded theory, perhaps because the theory focused more on processes than traits, and because the traits mentioned – patience, non-defensiveness, genuineness – were more interpersonal and specific in focus. The idea is theoretically attractive, that therapists’ overall psychological health would be related to their ability to manage and use their reactivity. However, none of the therapists chose to pass judgment on their own psychological health. In fact, the concept of accepting one’s psychological wounds or imperfection was relevant. This contrast raises the question: is a certain amount of pathology important to being an effective therapist, as some claim mental illness helps artists? Or is being a wounded healer only important when one is in fact wounded?
Those therapists in the present study who described themselves as having suffered psychologically did tend to attribute sensitivity to their clients’ suffering to their own difficult experiences. Spence (1982) argued that only through calling up emotions grounded in personal experiences can one person approximate knowledge of another person’s suffering. Taken too literally, this assertion would imply that only rape victims should work with rape victims, etc. Certain there are advantages to such closely parallel experiences: more accurate empathy, being able to draw from one’s own healing to guide therapy, being experienced by the client as credible. There are also disadvantages: the danger of assuming one understands another person’s experience, the possibility that one’s own unmet healing needs interfere in the therapy, and the possibility that one is personally invested in a certain method of healing that is not appropriate for the client. The more closely client and therapist experiences resemble each other, the more powerful both the advantages and the disadvantages may become.

The more disparate in kind or intensity the experiences, the more imagination is required of the therapist to empathize on an emotional level. The type of imagination required would seem to be sensitivity to the troublesome aspects of one’s own experience. For example, a therapist might reach into a past experience of being ostracized by two different peer groups to empathize with a bisexual client rejected by gays and straights alike. A therapist who had explored the personal meaning and experienced the feelings related to being rejected would be in a better position to empathize and also to know how the client’s experience might be distinctive. A further level of empathy would arise in knowing one’s own reactions to a wounding experience: defenses against feeling it, interpersonal coping. A therapist who has dealt with suffering with great efficiency and dispatch might be less attuned to a client than one who had gone down various dead ends in trying to cope. A third level of empathy has to do with existing
pathology: a therapist who views the healing process as ongoing and doesn’t pretend to perfect mental health may more easily understand and be patient with a client’s self-defeating tendencies, while modeling an attainable goal.

Everyone has experienced psychological suffering; whether such suffering becomes woundedness, i.e. has a negative impact on one’s ability to fully experience life or get needs met, is not necessarily a given. The experience of having worked through woundedness to an empathetic experience of one’s suffering, and finally to relative freedom from its influence, can certain deepen the reservoir from which a therapist may work. It would be interesting to study therapists who have not been psychologically wounded but who have been intimately exposed to loved ones who have, to learn whether such vicarious experiences could also form the basis of capacities as a wounded healer. It would also be informative to learn which types of clients need the kind of contact that wounded healers may provide, and which do not, in terms of presenting problem, or capacity for relationship.

The second part of self-integration, healthy boundaries, is reflected in virtually every therapist’s struggle with contact. The three defensive client stances, avoidance, aggression, and dependency, were all met initially with defensive reactions that contracted or expanded the therapists’ boundaries. A healthy boundary in a therapist may be considered an awareness of what is “me” versus “not me” and how the mechanisms of projection, introjection, and projective identification allow “not me” to enter “me.” Therapists can allow themselves to be affected without feeling that the self is attacked, when the self is not overidentified with attitudes or personality traits that are challenged by the client. For example, Therapist 7 became less identified with staying in control and was able to allow the deadness and overwhelming anxiety her client experienced to rest in her. On the other hand, therapists who become overidentified
with the client lose the sense of where “me” ends and “not me” begins, and end up being unable
to “hold” the client’s experience. Either the therapist loses objectivity, as with Therapist 11, or
has to keep the client at arm’s length to tolerate intense affect, as with Therapist 1.

In the above description the connection between the two parts, wholeness and boundaries,
becomes clear. A therapist who has a sense of integrity or wholeness can set boundaries at the
place where the client needs them to be, rather than needing to include or exclude the client in
order to maintain an identity based on identifications. Identifications are essentially one-sided
approaches to bipolar constructs, like in control versus chaotic, or perfect versus failure.
Therapists who incorporate opposites into their professional and personal identities have less to
defend.

Both research and ungrounded theory leave unconsidered the role clients may play in
moving mutual reactivity forward toward resolution. Surprisingly, clients are not credited with
any strengths they may bring to untangling an impasse. Too often the psychoanalytic literature
on countertransference management conveys sole responsibility on the therapist. While clearly
the client may not be in a position to be of much help, and should not be depended upon to do so,
still it seems infantilizing and far short of an intersubjective stance to lay the whole burden at the
therapist’s feet. A collaborative approach that recognizes the woundedness and healing potential
within both therapist and client (Whan, 1987) seems most likely to result in a strong working
alliance and an authentic real relationship.

Management of Reactivity

Of the three approaches to understanding reactivity management, quantitative research is
necessarily the least effective in identifying processes. Studies of manualized therapy allow
researchers to compare overall processes, but these by definition cannot include therapist responses to their own subjective reactions. Therefore this section primarily attempts a critical comparison and synthesis of grounded and ungrounded theory.

Transcendent and Embedded Approaches

As described in Chapter II, Coburn (1999) identifies two epistemological positions – beliefs about the nature of knowledge – that he sees as underlying countertransference (therapist reactivity) and its management. The transcendent position is associated with positivism and the belief in an objective, knowable reality. In practice this position is experienced as a therapist’s confidence that a certain understanding of the client is true. The embedded position is one acknowledging the therapist as feeling, thinking, perhaps even embodied person, like the client, both of whom can only know a subjective reality, even if it is shared at many points.

On one hand, Coburn (1999) sees transcendence as responsible for much reactivity due to the danger of therapists imposing interpretations that may grow out of their own unacknowledged needs. On the other hand, Coburn advocates for clinical flexibility, in that conviction about a transcendent truth may be important at certain points in therapy, while acknowledging the limits of subjectivity to one’s self or one’s client may be important at other points.

These two positions roughly correspond with the relational expert and wounded healer positions taken by different therapists participating in this study. Relational experts attempt to transcend subjective aspects of their own reactivity and arrive at an objective view of, and response to, their clients, while wounded healers tend to acknowledge their subjective reactivity.
While trying not to act on it in detrimental ways, they also use it to help their clients empathetically understand their own subjective reactivity.

One might conceive of a scale of attitudes toward reactivity, each coinciding with a theoretical position articulated at some point in the theoretical literature, and each existing somewhere in the transcendent-embedded spectrum:

(1) Classical/Transcendent position: Only subjective reactivity elicited by the client’s reactivity is recognized. Reactivity interferes in therapy and must be transcended.

(2) Totalistic/Transcendent-Embedded position: All therapist reactions are recognized. However reactivity is only useful when objective, i.e. that aspect not based in therapist needs. Subjective reactivity must be identified through immersion in the subjective experience, then transcended. Objective reactivity may be shared with the client or used as a basis of interpretation of the client’s problems.

(3) Intersubjective/Embedded-Transcendent position: All therapist reactivity is recognized as potentially useful. There is no purely objective reactivity. When approached with acceptance, subjective reactivity helps the therapist empathize more deeply and join with clients who are highly reactive. Acceptance helps the therapist transcend reactivity to a degree, but some embeddedness is inevitable and even desirable as a sign of common humanity.

Although all of the therapists saw their subjective reactivity as a potential hindrance to therapy, they either used their objective reactivity for interpersonal insight or used subjective reactivity to develop empathy and contact with clients. Some therapists saw their reactive tendencies as requiring cognitive containment more than empathic attunement, but they did find
use in their objective reactivity; therefore this group represented the totalistic position. Within this group, some also disclosed objective reactivity to help clients develop insight. A minority of therapists appeared to reflect the intersubjective position in their approach, in that empathic attunement to the client was tied to empathic attunement to their own unmet needs. Taken together, these twelve therapists seem to have held either an intersubjective or a totalistic view of reactivity: it can always be useful, and at times it can provide a corrective experience of connection between two imperfect human beings.

The totalistic and intersubjective approaches can be viewed as both utilizing a combination of transcendent and embedded attitudes toward reactivity. The totalistic approach, in attempting to winnow out objective reactivity from the dynamic interplay of needs and use it to understand and illuminate the client, takes a more transcendent approach ultimately, but requires a stage of immersion in one’s own subjectivity initially. Otherwise the subjective aspect of reactivity cannot be separated. The intersubjective approach transcends the reactive pull of psychological needs not by separating and containing them, but by accepting them through an empathetic awareness that covers both therapist and client. Thus the totalistic approach has more discrete embedded and transcendent phases, whereas the intersubjective approach seeks to maintain and integrate these modes.

Evolving models of a dual embedded-transcendent approach to reactivity can be traced through Racker (1957, 1968), Reich (1960), Bouchard, Seguin, and Normandin (1995), and Bacal and Thomson (1996), Coburn (1999), and Hahn (2000). Although couched in distinctive language, all of these approaches boil down to a capacity for both conceptualizing and affectively experiencing that which may produce anxiety; this willingness in turn comes from an acceptance of one’s self as human and reactivity as inevitable. Ironically, much of the theory
reviewed in Chapter II, including later contributions on intersubjectivity, focuses on elaboration
of conceptual frameworks for understanding the mechanisms of narcissistic wounding, shame,
and projective identification between therapist and client. In other words, while advocating a
dual approach, the authors help to shore up the therapist’s transcendent function rather than
exploring the experience of being embedded.

Only Bouchard et al. (1995) provide a rich description of this process of embedding one’s
self temporarily in subjectivity and the intersubjective field. Bouchard et al. identify three modes
of therapist awareness that span the spectrum from completely embedded to completely
transcendent. The completely embedded, “reactive” mode is seen as the least therapeutic and is
equated with acting out or defending against reactivity without awareness. The “objective-
rational” mode is transcendent, viewed as useful for understanding dynamics in client and self
but not for allowing the emergence and integration of unconscious needs or communications
from the patient. The “reflective” mode is viewed by Bouchard et al. as a parallel to Freud’s
concept of freely hovering attention, midway between the embedded and transcendent poles. The
reflective mode is comprised of four stages: emergence of unconscious material, immersion in
the material in a regressive manner, elaboration and integration of the material into existing
models of therapist or client, and interpretation. Bouchard et al. identify many points at which
the process can founder and lose itself in further reactivity, suggesting that understanding and
using reactivity may be an intermittent and arduous process.

The stages of the reflective mode closely parallel steps in the grounded theory, and this
parallel strongly supports the importance of loosening one’s grip on existing interpretations in
order to allow novel information or perspectives to emerge. Not all of the therapists interviewed
found themselves caught up in enactments of reactivity; some were able to monitor and manage
their reactive tendencies from the outset. Perhaps the objective-rational (transcendent) mode as a dominant attitude is an artifact of a time in which therapists were not supposed to bring intersubjective needs or subjectivity to their work; or perhaps therapists who work primarily through this mode did not find themselves in a study of successful reactivity management.

**Interpersonal Uses of Reactivity**

According to the grounded theory, there are four possible uses of reactivity: sharing understanding of client reactivity (interpretation), disclosure to the client of subjective reactivity, expressing genuine empathy for the client (when reactivity is used to understand client experiences), and making valuing contact. The theoretical literature has more to say about the first three uses; quantitative research again cannot address processes well.

**Sharing Understanding of Client Reactivity**

Interpretation is often mentioned in the psychoanalytic literature on countertransference management as a key therapeutic factor. Interpretation of client reactivity can only be effective if the client is certain that the therapist is not interpreting subjective reactivity and attributing it to the client. This point leads to consideration of self-disclosure (discussed below) but also of how to best frame interpretations of client reactivity. Clues are offered by the research design of some early studies, initiated by Yulis and Kiesler (1968). Other indications are given by a frequently referenced anecdote by a psychoanalyst (Tower, 1988) and by participants in the present study, especially Therapists 5 and 8. These three sources bring together the best of what each method of inquiry has to offer.
Yulis and Kiesler (1968) measured countertransference behavior by offering therapist trainees two choices of interpretation in response to taped analogues of clients. The countertransference option did not include the therapist in an interpersonal interpretation, e.g. “You seem angry” versus “You seem angry at me.” The second response is held up an ideal one in that it places therapist and client in relationship to each other, thus encouraging resolution of the countertransference-transference relationship, and development of the real relationship. This design might prompt readers who practice psychotherapy to ask themselves how easy or difficult it might be to make such interpersonal interpretations.

Tower (1956) described a therapy relationship with a verbally abusive client. The therapist tolerated such abuse for weeks before finally acting out by missing the client’s appointment. At first the client raged at her all the more, then broke into laughter and acknowledged how difficult it must be to listen to her barrage. Thus not all interpretation of client reactivity comes about in a controlled manner. In fact, the therapist’s acting out of what many people had either felt like doing or succeeded in doing to this client, would seem to be a traumatic re-enactment, yet it was therapeutic. Therefore therapists would do well to know that sometimes falling into the client’s drama may allow an interpretation to be made through action.

Finally, the grounded theory provides helpful insights into how therapist may share understanding of client reactivity. First, such interventions may be more descriptive or more interpretive. Descriptions offer data, such as how the therapist feels when the client acts a certain way. Interpretations connect data with possible causes, such as childhood trauma. Second, reactivity may be contrasted with genuine contact, to help the client connect subjective experience, behavior, and others’ responses. Third, therapists sometimes need to reveal their own reactivity before addressing the client’s.
Self-disclosure

Self-disclosure has been a controversial topic in psychoanalysis. Several theorists from the 1940s and early 1950s (Berman, DeForest, Little and Winnicott) advocated judicious use of self-disclosure of countertransference. Berman (1949) asserted that disclosure of CT that was adequately understood modeled the integration of reactions for clients who coped defensively with their own reactivity. Therapist 1 described this experience explicitly, and it may have played a role for Therapists 7 and 9. DeForest (1942) thought that disclosing countertransference helped strengthen clients’ reality functions, because they tend to sense something awry in therapists’ responses anyway. This position was not reflected explicitly by any of the research participants, although it seems that the confession of inattention by Therapist 5 allowed his client to explore the reality of others’ imperfect responsiveness in comparison to his dichotomous fantasy of either perfect attentiveness or abandonment. The construct of reality-testing did not arise among the research participants, but it is implicit in the idea of working through mutual reactivity to arrive at a real relationship. Winnicott (1949) did suggest that the real relationship would be enhanced by self-disclosure of countertransference, especially for clients given to psychosis. This assertion anticipated both intersubjective theory and the present grounded theory.

Hahn (2000) recommends that therapists both understand the connection between their reactivity and their clients’ disowned experiences of shame, and be willing to experience their reactivity without avoiding it. In this way therapists are less likely to avoid shame by identifying with a devaluing other, and instead give voice to the experience of shame so that the client can safely repossess the same.
Hahn (2000) might have been describing how Therapist 9 experienced and managed reactivity. The client initially identified with the devalued representation of self and over-valued the therapist, then avoided shame by identifying with and emulating the therapist. Later, the client identified with the devaluing representation of self and led the therapist to identify with the client’s devalued self. Only by owning and disclosing shame could Therapist 9 help his client let go of such defensive maneuvers.

Shame and narcissistic wounding also appear to play an important role in the challenges faced by Therapists 5, 7 and 11, although the management approach differed depending on whether projective identification was active in the client. Therapist 7 used the reflective mode to develop awareness of and interpret the client’s experience that was elicited in her, while simultaneously providing the client with valuing contact. Therapists 5 and 11 provided themselves with such contact in order to resolve shame and remove its interference from providing valuing contact to their clients.

Expressing Empathy and Making Valuing Contact

An empathic stance toward clients is implied in much of the literature as an ideal from which therapists deviate when countertransference interferes. However, there is little direct discussion of expression of empathy. Perhaps the psychoanalytic focus on interpretation is responsible: one definition of empathy might be an accurate, nonjudgmental interpretation of client behaviors and emotional reactions as resulting from or generative of suffering. The grounded theory makes the distinction that empathy must be felt in order to be expressed congruently and received by the client.
The theoretical literature does not address the therapist’s capacity for making valuing contact outside of expressing empathy, unless such contact would be implied in a concept like “therapeutic attunement” (Bacal & Thomson, 1996). Again, it is possible that such contact is viewed as the ground of all therapy and therefore not worth exploring. Interruptions of contact are however represented by such language as “intersubjective dysjunctures” (Bacal & Thomson, 1996), implying that contact between the two subjectivities of the therapist and client is a necessary component of successful therapy. Given its frequently nonverbal nature, valuing contact is also difficult to define or describe, except in its absence.

Management Results

Field studies of countertransference management have defined management results in terms of overall therapy outcome; relationships between countertransference behavior and outcome have not been entirely clear. Both the theoretical literature and the grounded theory attribute some measure of therapy success to a combination of corrective experience and understanding of reactivity, the relative importance of each varying with the client and perhaps with the theoretical orientation of the therapist. There was no opportunity to ask these therapists’ clients what they saw as the most powerful mechanisms of change. Nor would the clients of therapist falling more into the relational expert role know the degree to which therapist reactivity management played a part. In fact there is no way to clearly separate or measure the relative impact of therapeutic interventions related and unrelated to therapist reactivity. Therefore the best one can say is that (a) both the experience of and the understanding of intersubjectivity, both corrective and repetitive, were seen as important to outcome among these therapists, and (b) management and/or use of therapist reactivity was required in order to provide (a).
Therapist development was also considered a management result in the grounded theory. Research has not considered this question, and theory has rarely done so. The concept of bilateral healing was introduced by Brothers and Lewinburg (1999) to describe how both therapist and client may find a corrective experience in the therapy relationship. Freud (1910/1957) referred to the need for unending self-analysis with countertransference as a stimulus. The focus of the present study was the benefit derived by the client, and it would be difficult or impossible to identify all the interacting strands of cognitive and experiential learning in the therapist. However, the grounded theory does indicate that certain therapists experienced a shift in their approach to their own and clients’ psychological wounds, one that might be described as a move from a more transcendent to a more embedded position. Others seem to have transcended their reactivity more completely. These apparently contradictory trends are not necessarily so, as is described in the following section.

Conditions of Change and Growth

The therapeutic response to the client’s reactivity provides conditions of change and growth. There are embedded and transcendent levels to the therapeutic response: embedded by generating reactivity and offering present contact as this reactivity is explored; transcendent by stepping above and observing (and inviting the client to observe) the reactivity.

The construct of the wounded healer offers a further level of embeddedness and transcendence. First, the therapist as wounded healer may respond to the client’s reactivity with his or her own reactivity. This would be a bad thing if the wounded healer, conscious of his or
her wounding, could not transcend it and comment on it, at the same time offering the client a model of being able to catch one’s self in a wounded/wounding response and extricate one’s self. On an embedded level the wounded healer can provide an empathic engagement that is perhaps more profound for being connected to awareness of one’s own suffering and its commonality with the client’s suffering.

It seems that the psychotherapists participating in this study approached their clients either as relational experts who could offer a healthy engagement and help in learning how to relate and function in a healthy manner or as wounded healers whose own vulnerability became important to empathizing with and/or joining with the client. However, one could equally ask whether the clients played a large role in determining this response. Those cases in which the therapist exposed more human vulnerability might have been those which required it in order to move beyond an impasse. Those clients may have been more profoundly wounded or more deeply ashamed of their wounds. Yet it is impossible to make any valid comparisons; one cannot know whether in other cases the therapists could have become more aware of their own psychological wounds and used this awareness to add further dimensions of growth to the client’s experience.

This area of uncertainty highlights a question about the purpose of therapy. Is an experience of deeply present contact necessary for problem resolution? If not, is such contact an end in itself? Perhaps in those cases in which contact has been strongly contaminated by psychological wounding in the client’s history, genuine contact between two wounded people is a necessary part of developing trust. These also tended to be the cases in which strong personal reactions were evoked in therapists, so the sample here may not represent other cases in which a more expert therapist role may be sufficient. Therefore one should be careful not to generalize to
all therapy, unless one believes that deeply present contact is an end in itself, an experience of functional relating and not merely a means to problem resolution.

The paradox of corrective experience lies in acceptance of the person, the person’s needs, and the person’s suffering. For example, in Interview 7, the client needs to feel safe and has felt unsafe with contact, therefore the client avoids contact. Yet contact is itself a need, and the two needs generate ambivalence and a dilemma. The client expresses this ambivalence through the act of being present physically but psychologically removed. The dilemma is that this solution is itself wounding.

The therapist must recognize both sides of this dilemma and respond with countless interactions that represent safe contact. Otherwise the therapist is in danger of reinforcing the dilemma by responding to one side of it – either by pushing for contact in ways that feel unsafe to the client, or by giving up contact in favor of safety. The paradox is that safety is achieved by repeatedly being with the client in his or her unsafe dilemma.

Each therapy relationship has its own dilemma and its own paradoxical response. In Interview 1, the client needs both a separate sense of self and connection with others, and sees these as conflicting aims. The therapist learns to be with the client in this dilemma. In Interview 2, the client needs both autonomy and dependence. The therapist meets the client’s dependency needs but recognizes that she also needs to be supported in supporting herself. In Interview 3, the client needs both engagement and safety from violation, and the therapist, by verbalizing this dilemma and how it becomes her own dilemma, allows the client to invite greater engagement. In Interview 4, the dilemma is not resolved but the therapist does extricate himself from responding to one side of it. The client’s father needs both contact and control, perhaps control being a defense against being abandoned. The therapist learns to respond with greater contact but
a refusal to be controlled. In Interview 5, the client needs to be valued but also needs to learn how to tolerate variations in how others respond. The therapist’s lack of attentiveness paves the way to illuminating this dilemma and providing an experience of imperfect yet real contact. The therapist’s eventual acceptance of his own imperfection allows for greater contact rather than less. In Interview 6, the client needs both contact and safety from demands for intimacy. The therapist responds by accepting the client’s ambivalence and offering nondemanding contact. Interview 7 is discussed above. In Interview 8, the client needs both intimacy and safety from needs being seen as shameful. The therapist responds by overcoming his own shame and by showing how the client’s engagement or lack of engagement can be described without shaming. In Interview 9, the client needs to be accepted but fears revealing inadequacies that could lead to a greater rejection (of self rather than persona). The therapist works through his own shame and temptation to be idealized and is able to have contact about the shame. In Interview 10, the client needs to be accepted but is demanding in order to coerce acceptance. The therapist helps her look at her coercion in an accepting way and therefore the client is open to gaining acceptance in non-coercive ways. In Interview 11, the client needs to be both autonomous and dependent. The therapist is able to comment on this dilemma and accept the contradictory desires to be cared for and to not need anyone. In Interview 12, the client needs to have her voice heard but also needs to learn how to hear others’ voices. It is the therapist’s empathy that unlocks the client’s capacity to attend to others.

Thus in some cases the dilemma is resolved by naming it in an accepting manner, in others by responding to both competing needs in ways that bring them into coordination with each other. In certain cases the therapist has a parallel dilemma to work through, such as a conflict between wanting to both transcend and avoid awareness of a reaction. In any case, the
paradox of change presented by this group of therapists seems to hinge on their level of self-acceptance. When they do accept their own psychological needs as real, they are able to step outside themselves and ask themselves how to fulfill these needs without a negative impact on therapy or their clients.

Implications for the Three-Part Model of the Psychotherapy Relationship

Change and growth occur not only in the context of an encounter with reactivity and underlying needs, but also in the broader context of the therapy relationship. Gelso and Carter (1985, 1994) provided the psychotherapy research and practice communities with an invaluable heuristic tool in devising their model of psychotherapy. The working alliance, the transference-countertransference relationship, and the real relationship each seem to be indispensable elements, and their interrelationships suggest much about the mechanisms of psychological change and growth and the breakdown of these mechanisms (see Chapter II for a review of the model and integration with theory and research on countertransference management).

Asking twelve experienced therapists to describe challenging cases in which they seemed to manage their reactivity successfully casts new light on the tri-partite model and allows for greater differentiation. In this section the nature of the grounded theory’s core category, therapist reactivity management, is brought into relationship with the working alliance, the transference-countertransference relationship, and the real relationship to create three possible pathways the psychotherapy relationship can take.

In Chapter VII the heart of reactivity management was defined as bringing therapist and client needs into conscious relationship with each other. I would suggest that this process defines a shift in therapy from dominance by the transference-countertransference relationship, to
dominance by the real relationship. The different ways in which this process happens depend on the strength of each component of the psychotherapy relationship. If the client’s transference (and hence the interpersonal pull for objective reactivity in the therapist) is strong and the therapist’s subjective reactivity is strong, then the potential exists for the therapist to act as a wounded healer, for client and therapist to be in contact with each other’s subjectivity including unmet needs. The potential also exists for a breakdown of relationship through mutual escalation of wounding, or a symbiosis in which both help each other to avoid contact with their own psychological wounds. These would be different manifestations of a transference-countertransference relationship.

In contrast, if the therapist does not bring a strong subjective reaction to the client’s transference, but remains an “all good” object, then the real relationship is limited, and the working alliance may be expected to do work for which it is not designed. This work would be the creation of a real relationship whose depth encompasses a realization of both participants’ humanity, as a model for other relationships. The client may become more insightful and adept at recognizing and pulling away from transferential reactions in life, but still unable to surrender the ego ideal (that which the therapist has portrayed) as a superimposed template for health. Several of the therapist narratives demonstrate that only therapist vulnerability allowed the client to develop an accepting relationship both to another person and to self. This argument also contains my personal bias toward an existential-humanistic view of psychological growth, that it should not reinforce any split between the self-designated “rational self” and the reactive self, such that one is continually and distrustfully monitoring and controlling one’s self.

This argument seems to imply that therapists who do not have unresolved interpersonal patterns to be activated by challenging clients will be less helpful to those clients: the diametric
opposite of Freud’s position regarding countertransference. However, this implication misses the
fact, pointed out by Racker (1953), that all objective reactivity contains subjective elements. For
example, if an angry client pulls for a placating response, this is partly because the therapist is
reactive to anger. Just because a reaction is normative does not mean it lacks subjectivity. An
expectable response hinges on our shared pathology, not our shared health. A therapist who
responds with perfect compassion and composure makes it impossible to develop a real
relationship. The real relationship is important because it provides a lived model for relating as a
flawed/good human being to other flawed/good human beings. At the same time, the therapist
must take responsibility for subjective reactions and attempt to avoid acting them out in ways
that repeat transference-countertransference patterns. Such reactions must be made conscious,
possibly verbalized, and transcended through compassionate awareness.

This path is distinct from one in which the working alliance can in fact do the bulk of the
work because the transference is not strong and the client is not in apparent need or readiness for
a real relationship. Countertransference, or therapist reactivity, may still be strong, but it must be
contained through the same professionalism that allows the therapist to form a working alliance
with the client. As transference patterns are recognized the therapist provides a model for well-
managed relationships rather than the realization of shared humanity that the real relationship
implies. The therapist is more of a coach and interpreter in such cases: perfectly valid, useful
roles, and ones that help the client gain much-needed mastery.

Summary of Integration

An integration of research, ungrounded theory, and grounded theory yields the following
model of therapist reactivity management within the psychotherapy relationship. This
relationship has the qualities of structure, interpersonal process, and intrapsychic process (within both therapist and client). In terms of structure, the psychotherapy relationship contains a real relationship designed to satisfy the client’s and the therapist’s developmental needs, a transference-(countertransference) relationship based on (mutual) reactivity that frustrates such needs, and the agreement to work through the latter in order to strengthen the former and generalize to improvement in other relationships. The reactivity-based relationship produces anxiety over unmet needs that powers both the work of therapy and the continued reinforcement of defensive stances toward self and other. Conflict between the desired and existing relationship also leads to awareness and exploration of (mutual) reactivity. Awareness also generates anxiety due to the risks of shame and loss. The properties of the real relationship (compassion, containment, contact) unite transcendent and embedded functions, allowing the client to develop self-awareness without paralyzing shame or despair, and to let go of defensive stances toward relationship needs.

In order to offer a real relationship, the therapist must shift from a defensive stance that tends either toward transcendence of or embeddedness in the reactivity, to an awareness that unites both transcendent and embedded approaches to experience. The defensive stance avoids both shame (loss of good self) and abandonment (loss of good other) by either merging with the good other or by disavowing any connection with – or the goodness of – the other. Awareness allows for both reactivity and reflection upon that reactivity; one gains perspective without distancing from felt experience. Such is the dual nature of awareness, that one is both within and watching an experience. Therapist needs are owned and either disclosed or empathetically contained.
Helping the therapist to make the transition from being defended to being aware, are three interrelated qualities that contain both embedded and transcendent functions: empathy, openness to reactivity, and theoretical framework. Empathy fosters awareness by interpreting client behavior through the lens of psychological needs and wounding. Openness to reactivity does the same for the therapist interpreting their own behavior and impulses toward behavior. Theoretical framework provides the therapist with possible empathetic interpretations of both therapist and client behavior, as well as understanding of how these are dynamically related to each other. The therapist as participant-observer must be embedded in the therapy relationship (both real and transference-countertransference) to experience it, and also able to transcend it enough to interpret it.

Depending on how deeply embedded either therapist or client is in reactivity, the therapist can view and use self as a wounded healer or as a relational expert. The effort to paradoxically accept and transcend reactivity must be all the more powerful when the therapist is deeply embedded, and the compassion needed for such transcendence is fueled by the therapist’s awareness of the suffering experienced by the therapist, the client, or both. As a relational expert the therapist can provide a real relationship as well as instilling awareness of client reactivity, so long as recognition of common psychological wounds is not necessary to join with the client. The client may in fact be less threatened by shame than by abandonment, and therefore be more threatened by the possibility that the therapist is wounded than by the possibility that the therapist is not.

The paradox of accepting and transcending makes bridges from unaware suffering to aware suffering to acceptance and response-ability. Acceptance and response-ability are the two pillars of health in that acceptance is the appropriate stance toward unavoidable suffering, and
response-ability is the appropriate stance toward avoidable suffering. Lack of acceptance and inaction or acting out are the hallmarks of the reactive/defended position. Ideally, the therapist approaches the client with a greater capacity for acceptance and response-ability than the client yet possesses, and calls these forth in the client through the intersubjective experience, but only when the therapist’s own difficulty accepting or responding has been overcome or is overcome in the process of the therapy.

**Intersubjectivity Revisited**

Given the central position of intersubjectivity in this integration of theory and research, it seems important to more deeply define what is meant by this process. What is the ontological ground of intersubjectivity? Is it entirely relativistic, or is it anchored to some objective constant? Are psychological needs and their interplay between two people entirely constructed by those two people? Ironically, it would seem that reduced down to its core, the universal human psychological need is intersubjectivity. We need to relate to others and through this relationship know ourselves and each other to the extent this is possible. If intersubjectivity is both the need and the process through which we meet (or frustrate) that need, then there is no destination at which one can arrive. One can only hope to foster the conditions in which intersubjectivity can happen, inside and ultimately outside of the therapy room.

And how is intersubjectivity known: what is its epistemological ground? One can never know a human interaction from a privileged, omniscient perspective. Even if one could know all there was to know about both the therapist’s and the client’s conscious and unconscious motivations and their expressions in behavior, one would be missing the limitations on knowledge of self and other imposed by one’s subjectivity. Therefore intersubjectivity is also its
own ground epistemologically. Awareness only happens through relationship (intrapsychic relationships included), and relationship is constituted of shared awareness.

Defined in the light of this grounded theory of therapist reactivity management, therapy is the practice of intersubjectivity, in which one person is primarily responsible for continuously intending greater awareness of subjectivity and its expression in the relationship. Reactivity on either side signifies both the breakdown of intersubjectivity, as well as material for deepening awareness and its expression. Only when reactivity is embraced as part of intersubjectivity, rather than being ignored or viewed as an unwelcome intruder, does it become available to change and growth processes in both therapist and client.
Chapter X

DIRECTIONS FOR FUTURE RESEARCH
ON THERAPIST REACTIVITY MANAGEMENT

Introduction

Research methods should follow from the questions being asked, rather than preferred methods dictating research directions. With this principle in mind, one can also appreciate that the state of knowledge about a given area of inquiry may influence the methods most appropriate for learning about it. Therapist reactivity (or countertransference as it has been designated in the literature) has a rather curious research history. One the one hand, psychoanalytical thinkers and their theoretical descendants have been teasing apart and reweaving the strands of therapist reactivity and its management for almost a century, with the greatest activity in the 1940s, 50s, 80s and 90s. Although such theory should be distinguished from systematic research, it was often rooted in case examples and a synthesis of clinical experience. On the other hand, controlled inquiry on therapist reactivity has been conducted for about four decades, and empirical study of reactivity management has been conducted for half that time, representing only about a dozen studies. The product of this unbalanced history is a richly differentiated body of theory with a handful of empirically supported relationships. Therefore we know a lot about reactivity and its management without knowing for certain whether we really know it.

This observation would seem to support a strong focus on confirmatory, quantitative research for the near future. However, one should bear in mind that the body of theory from which hypotheses would be derived has been biased toward psychoanalytic concepts and practice. While richly elaborated, theory has also been fragmented and contradictory. Therefore
now appears to be a fitting time to explore reactivity management in the context of contemporary clinical practice, as a whole process.

Exploratory Research

The present study attempts such an exploration, and the participating therapists represent a broader range of theoretical orientations than found in the literature on countertransference. However, theoretical sampling was not pursued in this study far enough to achieve theoretical saturation – the point at which adding further sampling of therapist accounts seems to add nothing to understanding the process. Even at such a point it is impossible to determine whether saturation has more to do with a theory’s coherence and completeness, or more to do with the investigator’s saturation with the theory, such that interpretation of novel data is biased toward absorption into the existing theory. Still, replication of the present study could be helpful in order to identify more exhaustively the range of content within each category (for example, possible types of reactive behavior in therapists) and the possible pathways through the reactivity management process (for example, conditions for self-disclosure). If further study yields the same range of theoretical possibilities, then the trustworthiness of the existing theory is further enhanced.

Replication in grounded theory differs from the same activity in quantitative research in that one is not seeking to control all variables and determine whether the power of a relationship still holds with a new sample. Instead, replication of the present study would mean seeking another group of nominated therapists, asking them the same questions, and developing a grounded theory entirely independent of the present one. It might even be necessary that the investigators be new and not be exposed to the present theory. Otherwise the tendency to see the
same constructs and processes could be irresistible. Once the two independent theories were articulated, one could compare and contrast them in order to achieve a synthesis. Several iterations of this replication process would result in a robust, trustworthy theory – not in the sense of being generalizable to all psychotherapists, but in the sense of providing a reliable map of the potential terrain of reactivity management.

Several variations of theoretical sampling, retaining the same basic grounded theory approach, could prove useful in further differentiating the process of reactivity management. A particularly useful approach would be to compare examples of successful and unsuccessful reactivity management. The sample might have to be large enough to permit some matching of initial reactivity. An alternate approach would be to ask therapists to contrast their own successful and unsuccessful cases. It may be difficult to identify therapists willing to openly discuss cases in which reactivity derailed therapy; one way to overcome this barrier would be to seek out therapists with long careers and good memories who could identify early blunders and later modifications. Logistical barriers aside, the benefit of such a comparison would be the identification of decision points at which success or failure could be determined. Given that therapists in the present study were able to recover at various points – some before and some after the point at which reactivity was acted out toward the client – there may be multiple exits from a reactivity-burdened pattern of interaction. In fact, comparison of successful and unsuccessful cases could help determine when some acting out of reactivity can serve to deepen the real relationship or become the basis for a vivid interpretation of mutual reactivity.

Another illuminating comparison would result from a sample of therapists who shared a view of therapy distinct from the psychodynamic assumptions that most participants from the present sample seemed to share. For example, it would be interesting to learn how therapists who
describe themselves as primarily cognitive-behavioral in orientation would understand their reactivity and its management. Another variation would be to seek racial and/or ethnic diversity within a sample of therapists. If Therapist 4 is any indication, then culture and relationship to the majority culture could certainly play important roles in both reactivity and its management. Therapist-client dyads of differing race or ethnicity, sexual orientation, or socioeconomic status could also present previously unexamined challenges in terms of reactivity management, although such differences do not necessarily lead to predictable forms of reactivity.

Differences in diagnosis could also have important implications for type and intensity of reactivity, as well as strategies for managing it. The dissociative clients of two of the therapists in the present study presented certain challenges in common. Studying reactivity management with clients with personality disorders could yield insight into the objective and subjective components of reactivity, due to the fact that personality disorders are likely to evoke reactions in therapists that have both universal and therapist-specific components. Keeping the client diagnosis constant within the sample – say, twelve dyads in which the client has borderline personality disorder – would yield much valuable information about both subjective reactivity for therapists to look for, and useful responses.

Other diagnoses offer special challenges. Clients with thought disorders often evoke primitive reactions in therapists, as Winnicott (1947) described. Posttraumatic stress disorder may lead to vicarious traumatization in therapists (Collins & Long, 2003), perhaps especially when therapists themselves have been traumatized. Anorexia nervosa is another diagnosis that therapists find challenging due to its inflexibility and high risk. Addictions also present difficulties related to resistance to treatment, and therapists may be more directive, resulting in different constellations of client and therapist reactivity.
Particular behaviors may also act as triggers of reactivity, such as chronic suicidality, self-mutilation, pedophilia, and domestic violence. Populations exhibiting destructive or morally repugnant behaviors are often served by clinicians with less training and supervision than clinicians who see clients with milder disturbance. Attention to therapist reactivity may be scarce in publicly funded settings and those in which treatment is mandated, yet in these settings therapist reactivity may run high.

A final variation to pursue in theoretical sampling involves going beyond individual adult psychotherapy, to child therapy, family therapy, couple therapy and group therapy. Families and couples may be more likely to constellate family dynamics that are familiar to the therapist, and to induce role-based behavior as the family pulls the therapist into the family system. Children could be expected to evoke distinctive reactivity, whether based on identification with the child or with the child’s internalized parental objects. Couples may stir feelings related to the therapist’s own partnership difficulties. Groups create a nexus of reactivity that is so complex as to be daunting yet instructive in the same measure (see Hayes and Gelso, 1995, for a discussion of countertransference in groups).

Although in the present study a theory was developed that encompassed one family and one couple as well as ten individual clients, the question remains whether further theory-building would be necessary to truly capture the structure and process of reactivity management in these cases. Reactivity management with families could be understood as a modification of the individual therapy model, but the systems theory principle of emergent properties suggests that family therapy has reactivity dynamics different in kind and not only in quantity from those operant in individual therapy.
Confirmatory Research

While replication and variation of the grounded theory approach may deepen, broaden, and strengthen the results of the present study, it would also make sense to test the existence and strength of relationships between specific variables, continuing the program of research conducted by Hayes and colleagues. Most empirical study thus far has utilized analogue designs, which have limited relevance to clinical practice – neither the operationalization of the variables, nor the degree of control in the analogue design, allow much inference about therapy process. Field research would be more complex and time-consuming, but ultimately more rewarding.

Research designs should imitate the basic structure of the reactivity management process as outlined in the grounded theory. One may consider reactivity causes and management facilitators to be independent variables, reactivity behaviors and management strategies to be mediating variables, and reactivity effects and management results to be dependent variables. Research designs that incorporate all three types of variable seem to have the best chance of representing the actual process. Research in the past has tended to focus on potential relationships between management facilitators and reactivity, or management facilitators and management results. Assuming that reactivity management is occurring in the black box between the input of reactivity or facilitators and the output of management results, simplifies the research situation, but removes from the process the heart of reactivity management as defined in the grounded theory: the act of bringing therapist and client needs into conscious relationship with each other. On the other hand, one cannot set up treatment and control groups with the idea that certain therapists will manage their reactivity and others will not.

One solution may lie in linking qualitative and quantitative methods. First, a brief digression on a research method that would allow the operationalization of some important
constructs that emerged from the grounded theory. Luborsky (1972) developed a measure of Core Confictual Relational Themes (CCRT) that he was able to use in systematically researching transference within psychodynamic psychotherapy (Luborsky & Crits-Christoph, 1990). CCRTs are identified by analyzing narratives of relationship episodes: thematically bounded interactions between therapist and client, either about relationships external to therapy, or the therapy relationship itself. The CCRT is comprised of three related elements: a wish for a certain response from others, the expected or actual response from others, and the response of self to that response of others.

Cluster analysis has yielded 8 clusters of wishes: to assert, to hurt/control, to be hurt or controlled, to withdraw, to be close, to be loved and understood, to feel good and comfortable, and to achieve or help. Responses of others fell into 8 clusters: strong and independent, controlling, upset, bad, rejecting, helpful, liking others, and understanding. Responses of self were clustered into 8 types: open and helpful, unreceptive to others, respected, opposing others, self-controlled and confident, helpless, disappointed, and anxious or ashamed. An example of a complete CCRT might be the wish to assert one’s self, a rejecting response from others, and an ashamed response of self. Thus relational themes overlap significantly with themes described by the research participants in the present study.

Although primarily used to identify core themes for clients, the CCRT method could also be used to identify therapist CCRTs, through relationship episodes recounted to their supervisor or a researcher, or observed during sessions. These CCRTs could be compared to those of clients, and complementary or concordant identifications could be identified to determine whether reactivity was more easily activated – and had adverse impact on measures of treatment outcome – in those cases than when therapist and client CCRTs did not bear a clear relationship
to each other. This study of reactivity would set the stage for a program of research on reactivity management.

Given therapy dyads in which concordant or complementary identifications were experienced and activated mutual reactivity, two reactivity management processes identified in the grounded theory could be operationalized in part through the CCRT method. The first process is the therapist’s empathetic understanding of both self and client. Empathetic understanding is meant to include both emotional and cognitive aspects: an experience of what it must be like for the client (or is like for the self), compassion for that suffering, and an understanding of how that suffering arises and is expressed (or pushes for expression) in behavior. In interviewing the therapist, the emotional aspect of empathetic understanding for the client could be captured through an interviewer rating of the therapist on an empathy scale, e.g., the Empathic Understanding subscale of the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962). The cognitive aspect could be captured through coding the CCRT expressed in the therapist’s narrative about the client’s reactivity, and comparing this with the CCRT emerging from the client’s own accounts (based on a transcript of therapy) to determine degree of fit. The therapist’s empathy for self would be identified and measured in a similar manner, except that accuracy would be assumed.

Before going on to the impact of these variables on management results, it seems worth noting that the relationship between therapist empathy for self and empathy for client could also be usefully examined. The grounded theory suggests that there is a positive relationship between therapists’ empathy for self and empathy for the client, and that each may set the stage for the other.
The second management process to be operationalized is the therapist’s shift from reactive behavior to responsive behavior. This too could be coded through the CCRT using relationship episodes, whether recounted by the therapist or observed in action through the therapy transcript and/or videotape.

According to the grounded theory, management results in the client would parallel management processes: new interpersonal behavior in response to the therapist’s shift in behavior; and empathetic understanding of the client’s own reactivity. Again, these could be identified through coding relationship episodes for wish, other’s response, and response of self.

The value to the client of these changes would be assessed through general measures of psychopathology, such as the Brief Symptom Inventory (Derogatis & Savitz, 1999), or of interpersonal problems, such as the Interpersonal Adjectives Scales-Revised (IASR: Wiggins, Trapnell, & Phillips, 1988), both of which have demonstrated strong validity and reliability.

Hypotheses to be tested through this model would include:

1. Therapist’s empathetic understanding of client’s reactivity predicts client’s empathetic understanding of client’s reactivity.
2. Therapist’s empathetic understanding of own reactivity predicts client’s empathetic understanding of self.
3. Therapist’s empathetic understanding of own reactivity predicts therapist’s empathetic understanding of client’s reactivity.
4. Therapist’s empathetic understanding of own reactivity predicts change of behavior toward client from participation to non-participation in client’s core conflictual relationship pattern (i.e., therapist does not fulfill expected response of other).
5. Therapist’s empathetic understanding of client’s reactivity predicts change of behavior toward client from participation to non-participation in client’s core conflictual relationship pattern.

6. Therapist’s non-participation in client’s core conflictual relationship pattern predicts client’s development of new and non-conflictual relationship episodes (corrective experiences).

7. Client’s corrective experiences predict reductions in subjective distress and interpersonal problems.

The danger seems to exist that these hypotheses, even if all empirically supported, might create such a long string of correlations as to fail to demonstrate any actual mediating effect of reactivity management on a relationship between therapist reactivity and therapy outcome. However, the CCRT and the corrective relational experience would provide the necessary narrative coherence. For example, if a therapist empathetically understood his submissiveness complementary to the client’s dominance, empathetically understood the client’s dominance as expression of a thwarted wish for contact, shifted by meeting the dominance with assertive warmth, and the client responded with assertive warmth and became less dominant in other relationships, then the possibility that other therapeutic factors were responsible for the change would still exist, but the connections would at least be clearly united by the basic theme of dominance and submission.

Other research directions are certainly possible, and the reader is invited to be curious about other relationships. For example, do management facilitators like consultation and reflection make a difference; is the unexamined reactivity actually more harmful than the
examined reactivity? Do therapists who identify themselves as wounded healers work better with their reactivity than those who don’t, and how much healing do they require first? Questions like these may occur to the practicing clinician, and systematic inquiry need not wait on published studies. The following section addresses the application of grounded theory principles to the research-practitioner model.

Integrating Theory, Research, and Practice

Beyond graduate school and supervision, therapists must develop their own means of ongoing professional development. It has been widely noted that therapists in practice find it difficult to utilize traditional positivist research in their work (e.g., Polkinghorne, 1999). In presenting my rationale for the present study I suggested that grounded theory could fulfill an important function in bridging the gaps among theory, research, and the practice of psychotherapy. Grounded theory adheres to a rigorous method of analysis, stays close to experience, and offers levels of abstraction and specificity that are useful to therapists. In this final section I offer some further thoughts about the potential role of grounded theory in psychotherapy research and practice. Here are these thoughts in brief:

- Grounded theory may serve as a tool for catalyzing the professional development process.
- Grounded theory can crystallize clinical wisdom into a more coherent body of practical guidance.
- Grounded theory can guide programmatic research and help researchers avoid a hit-or-miss approach to developing hypotheses.
Grounded theory may serve as a tool for catalyzing the professional development process. Therapists necessarily bring to their encounters with clients a more or less stable network of assumptions about the organization of the psyche, the organization of families and other social groupings, change processes within each, and the role of therapy and the therapist in promoting such change processes. When clients fail to respond in ways predicted by such assumptions, therapists are faced with choices: they can continue to rely upon existing assumptions, drawing upon constructs like “resistance” or “entrenched character disorder” to explain the lack of change and perhaps to guide interventions; they can examine whether they are in fact practicing what they believe, and possibly identify their own processes that are interfering in adherence to their own principles; or they can revise their assumptions, all the way from core constructs to subtle technical issues.

In order to provide themselves with some sense of coherence and predictability (see Kelly, 1955, for the importance of anticipations), therapists are not going to question their core constructs unless they have to, i.e., unless repeated or dramatic therapeutic failures occur. Thus the high level of anxiety experienced by novice therapists exposed to multiple theoretical orientations. However, in smaller ways therapists who are dedicated to lifelong improvement of their skills, or those who have challenging clients, are constantly using observations of client responses to refine technique and the mini-theories in which such technique is embedded (Jennings & Skovholt, 1999). There is a cyclical process of observe-interpret-revise-respond: observe client behavior, interpret it in context of therapy relationship, revise mini-theory of overall therapeutic approach with this client, respond to client on the basis of this revision.

A good example comes from the reactivity management described by Therapist 6. Initially the therapist interpreted the client as narcissistic and despaired of helping the client
develop a greater capacity for relationship. However, the therapist was not satisfied with the limits on her responsiveness imposed by her own conception of the client. She turned to her ongoing object relations training group for help in reconceptualizing the client and the therapy. The training group, with its integration of a coherent body of theory and consultation regarding current clients, helped the therapist revise her mini-theory about this client and this therapy. Over time the fruits of this revision were borne out in client progress.

Object relations theory itself grew out of an iterative testing of psychoanalytic theory in practice with personality-disordered clients. Therapeutic failures raised questions that object relations theory seemed to answer. Grounded theory differs from such theory development in that grounded theorists are accountable to a relatively exhaustive process of making the link between data and theory explicit, and using a data set that includes potential counter-examples and variations. If Therapist 6 had used grounded theory to explore her impasse with her client, she would have spoken with perhaps a dozen or two dozen therapists treating clients with schizoid personality organization. She would have asked a consistent set of questions about the process of helping such clients develop a greater capacity for relationship, and identified themes and variations. She would have compared the theoretical constructs guiding each therapist, perhaps learning whether they made a difference in therapeutic approach, and in the process would have further differentiated her own constructs and gained a broader range of potential interventions.

Thus grounded theory fits closely with the normal process of therapist development triggered by therapeutic impasses, failures, and challenges, with two clear advantages. First, grounded theory to some extent avoids self-confirmation bias. For example, object relations theory predicts that people who evidence schizoid defense mechanisms warm up to relationship
quite gradually. A grounded theory study might expose a case in which progress was rapid. Self-confirmation bias would cause a therapist saturated in object relations theory to conclude that the client couldn’t have been very schizoid to begin with – perhaps was an avoidant personality. The grounded theory study would offer a level of richness that would preclude an unreflective absorption of data into existing theoretical biases.

The second advantage of grounded theory over the normal process of therapist development is that it offers a more compact and thorough process of differentiation, i.e. increasing sensitivity to context in clinical decision-making. For example, therapists who are open to the use of self-disclosure often have some theoretical constructs and clinical wisdom to guide them when deciding how, when, and how much to disclose to clients of their personal reactions and experiences. When clients react to self-disclosure in ways that impede therapeutic progress, or when therapists risk disclosures that feel right but fly in the face of theory, therapists then differentiate their understanding. A grounded theory would add predictive power, making the trial-and-error process more efficient.

How then can therapists apply some of the principles of grounded theory to their professional development without having to wait for an extensive body of such theory to be published? One way is to engage in a higher degree of comparison among their own clients, with other therapists, and between what they observe and what their theories predict. For example, a therapist may see a number of couples whose marriages suffer from a lack of passion. The therapist notices that she generally finds these couples more challenging than those with high levels of conflict. She then engages in an informal grounded theory study simply by observing themes within and across distant and conflicted couples she sees. She consults with two other therapists and gains further examples. She comes across a few articles and compares these to her
experience as well. She then develops a process chart describing successful and unsuccessful courses of therapy, noting contributions made by client characteristics, therapeutic interventions, and therapist reactivity. She questions her own biases in how she interprets success and how she justifies her interventions. This therapist has incorporated many of the principles and methods of grounded theory without having to invest the resources of time and energy required by a grounded theory study. Although she hasn’t been as rigorous as a grounded theorist, she has moved in that direction, with consequent clinical rewards.

Below is a series of steps for applying grounded theory principles to ongoing professional development. A common barrier to such efforts is lack of time – not to mention theoretical complacency. This template offers great flexibility: one can devote an extra fifteen minutes to applying these principles to reflection or consultation, or one can go much further, depending on one’s level of motivation and lifestyle.

**Figure 12: Applying Grounded Theory to Professional Development**

**Bracketing Biases:** Write down your assumptions about working with a particular type of client or in a particular modality (e.g., group therapy) or theoretical orientation.

**Theoretical sampling:** Identify clients of your own and/or of colleagues who fit the type, modality, or orientation. The sample should be of manageable size for the steps below.

**Constant comparison:** In your sample identify themes and variations, by asking successively of all possible pairs of therapy relationships, “How are these two therapies the same?” and “How are these two therapies different?”

**Attention to Context:** Identify influences from outside the therapy relationship that seem to have an impact on the process you are trying to understand. Examples: session limits imposed by managed care, therapist and client cultural backgrounds.

**Process Paradigm:** Based on the comparisons, map out steps in the process you are trying to understand (for example, existential therapy with adults with generalized anxiety disorder). Try to identify a core concept in the process and reflect on its nature.
**Multiple viewpoints:** Gather other perspectives on the same process, by asking colleagues, your clinical supervisor and, to the extent that it can be therapeutically useful and not harmful, your own clients. Consult relevant literature. Synthesize viewpoints but avoid reductionism.

*Grounded theory can crystallize clinical wisdom into a more coherent and trustworthy body of practical guidance.* Imagine a psychotherapy primer on Posttraumatic Stress Disorder consisting entirely of a series of grounded theory studies on such clinical issues as intervention in dissociative episodes, constructing new narratives that make sense of trauma, coping with therapist reactivity when trauma resonates with existential fears, etc. All of these studies would be rich in clinical vignettes, thorough in identifying themes and variations, and deep in arriving at a theoretically coherent view of the process in question. Contrast such a primer with the three resources that usually exist: studies testing particular relationships between interventions and outcome, but through measures too abstract to apply easily to practice with a particular client; theory that is not rigorously grounded in data; and clinical lore passed from therapist to therapist, scattered in fragments.

When they are not experience-near, theories tend to compete with each other for our allegiance purely through their rhetorical elegance. In contrast, grounded theory does not exclude other possible interpretations, but it does make sense out of experience. Theory can become so self-referential that it seduces us with conceptual consistency and clarity but leaves us wondering if it maps well onto lived reality; thus some of the distrust of psychoanalytic theory (Spence, 1994).

Grounded theory provides a paradigm broad enough to encompass any change process, with its components of core category, causes and consequences, and contextual factors. This paradigm can help to relate bits of clinical wisdom to each other, and avoid misapplication. For example, a therapist might believe the statement, “You don’t make people more suicidal by talking about suicide.” Ignorance of contextual factors might lead the therapist to question
suicidal leanings in a client with hysterical tendencies, helping him to escalate his interpretation of a life problem and avoid the emptiness he is trying to mask. Grounded theory offers a means of linking fragments of clinical lore into coherent, well-differentiated theories.

*Grounded theory can guide programmatic research and help researchers avoid a hit-or-miss approach to developing hypotheses.* Grounded theory offers another form of coherence in that it allows researchers to explore phenomena rigorously before identifying hypotheses to test through quantitative methodology. For all its claims to superior rigor, the quantitative approach fails to be rigorous at a crucial juncture: the beginning. A researcher interested in studying a phenomenon typically takes certain steps: a literature review, some mental play sketching out possible studies, and attention to how the potential strength and nature of a relationship between or among variables affects the choice of method. However, what is lacking is a careful examination of the phenomenon itself. Instead, quantitative researchers tend to put the cart before the horse by trying to understand a phenomenon by testing relationships. I would argue that in the social sciences, studies testing hypotheses should be confirmatory rather than exploratory. Exploration should be the province of qualitative inquiry. Null hypotheses are likely to be refuted more often when the ground work has been done to identify constructs and relationships that emerge from data rather than being imposed on data. Although null hypotheses are informative, they are less informative than refutations of the null hypothesis, and they do represent a relatively inefficient research process. The accumulation of valid and reliable psychotherapy research results is necessarily gradual, but could be more systematic if grounded in grounded theory and other qualitative explorations.
Chapter XI

IMPLICATIONS FOR EDUCATION, TRAINING AND PRACTICE

Introduction

This chapter considers the possibilities for improving therapist training and practice through consideration of the results of the present study. These possibilities may be the most important contributions of the present study, in that they may have a legacy beyond any impact on the individual reader. Clinical supervision, graduate school, and outpatient practice are discussed as contexts for facilitating awareness, management, and use of reactivity.

Clinical Supervision and Reactivity Management

Supervision of psychotherapists in training must be responsive to the development of the trainee (Stoltenberg, 1981). Supervisory responses that anticipate the trainee’s development could raise anxiety and complicate the clinical decision-making process. At what point should awareness of reactivity be introduced?

Based on the persistence of reactivity in experienced therapists and the ideal of the wounded healer that some therapists attempt to embody, it seems important to offer early education on personal reactions, during the time when trainees are forming basic constructs that may guide their future development as psychotherapists. On the other hand, supervisors should not automatically ascribe trainee behaviors that are counter-therapeutic to reactivity, when such behaviors could be more usefully addressed in terms of skill development. A trainee who is
overly educational versus exploratory toward a certain client at a certain point in therapy may be relying on known schemas for interpersonal helping, rather than retreating from threatening material. The supervisor should avoid assuming in either direction, that a trainee is reacting to a client or that a trainee is reacting to the novelty of the therapeutic relationship.

In any case, given the prevalence of therapists in this study who affirmed the usefulness and ubiquity of their reactivity, the first task of the supervisor seems to be normalization of such reactions. Trainees may be encouraged to learn that therapists at all levels of experience and expertise find themselves not only experiencing emotions and thoughts toward clients that may be out of line with the ideals of empathy or unconditional regard, they may even get caught up in maladaptive patterns of interaction. In fact, interpersonal psychotherapy theory (Levenson, 1995) emphasizes the inevitability of feeling this “pull,” and its usefulness to helping the client experience and understand their patterns as they happen. In addition to “pull,” however, it also important to normalize “push,” in that all humans bring maladaptive tendencies to their interactions.

A supervisor can perhaps best set the trainee’s mind at ease by giving personal examples of such pushes and pulls; the supervisor has power when filling the role of the trainee’s ideal, and this ideal must not be perceived by the trainee as unattainable. Beginning trainees may harbor fears that their reactions to their own histories will make them unsuited to be therapists; although this can be true, it seems more often to be the case that open exploration of such reactions in supervision or therapy can make a person with considerable emotional problems a highly sensitive and effective therapist (Gorkin, 1987, pp. 76-80). Several therapists interviewed for this study (1, 3, 7, and 9 especially) described how their own difficult childhood experiences made them sensitive to and able to connect with clients.
Second, the beginning trainee should be encouraged to engage in awareness of several components of the therapy relationship, identified through the questions in Table #. This awareness can be difficult for beginners, who are often simply trying to manage their anxiety about saying the wrong thing. The supervisor can guide the therapist by noticing behaviors or thoughts that seem to be rooted in reactivity, and contrasting these with the therapist’s norm.

A third supervision task related to personal reaction management is to offer the trainee a place to sort out reactivity. Most important here is the holding environment, the supervisor’s empathy and valuing contact that the trainee can internalize. The concept of parallel process (McNeill & Worthen, 1989) also suggests that if the supervisor can help the trainee sort out personal reactions and develop more flexibility in responding to them, even render them harmless through the transformative power of compassion, then the trainee may also be able to do so for clients. Such modeling may be more useful than many a course on psychotherapy theory and methods.

Finally, a supervisor can provide the trainee with an explicit model for continuing to notice and resolve or contain personal reactions, such as the grounded theory presented here. Part of this paradigm is a language for noticing possible types of reactions, such as gratification, avoidance, and aggression, and their connections to emotional and cognitive dimensions. Figure 13 (p. 277) presents a list of questions keyed to steps in the Causes-Reactions-Effects paradigm. These questions may be helpful for a trainee, but also for an experienced therapist. Several therapists interviewed for the study noted that it was useful to think about their work in the interview process. The questionnaire provides a format for self-interviewing, or it can provide a structure for dialogue with a supervisor or consultant.
Figure 13: Personal Reaction Questions for Psychotherapists

1. What thoughts/feelings do you have toward this client/ toward yourself when with this client?

2. What do you feel like saying or doing in response to this client?

3. What is the client doing or saying that elicits this response?

4. Do you feel pulled into a certain role with this client? How would you describe this role?

5. Do you feel a bond or identification with this client? In what ways?

6. How does your interaction with this client differ from your therapeutic norm?

7. How does the client remind you of an important person in your life?

8. How has this person in your life affected you in terms of your human needs?

9. What do these thoughts tell you about your own needs and how the client may affect them?

10. How have these needs affected you and your relationships?

11. What would be a helpful attitude toward your own needs?

12. How can you apply this attitude when with your client?

13. What other ways can you now imagine feeling, thinking and acting toward the client?

14. What do you anticipate will be the effect on the client of your new response?
A double bind can arise for trainees who are worried about performance, evaluation, and how these are connected to their own psychological health. If being a good supervisee means openly sharing personal reactions to clients, but being a good psychotherapist means being relatively free of such reactions, and evaluation is attached to both supervisee and psychotherapist performance, then the trainee can end up walking a tightrope in terms of how openly to address personal reactions.

My suggestions are to address this issue in supervision, to apply evaluation to the supervisee role and not the psychotherapist role, and to address the gatekeeping function of supervision through an exploration of the trainee’s personal reactions. The supervisor should be explicit at the beginning of the supervisory relationship about what kinds of personal reactions, behavioral or subjective, might raise red flags about the trainee’s ability to be a therapist with particular clients or in general. The double bind described above should be explored in the context of the supervisor’s philosophy of evaluation, expectations of the trainee, and the trainee’s experiences and concerns with being evaluated.

In summary, clinical supervisors can help psychotherapy trainees to develop their awareness and use of reactivity by modeling human fallibility and vulnerability; asking exploratory questions; providing a holding environment in which to safely explore reactivity; offering a model for how to understand and manage reactivity; and carefully explaining the use of evaluation outlined above.
Although the supervisory relationship may offer the psychotherapy trainee an affirming holding environment for personal and professional development, the academic culture of frequent evaluation and the relative lack of power students may experience in relation to professors can influence students to be more guarded about their vulnerabilities. The trainee may carry such concerns consciously or unconsciously into supervision, and the supervisor is often the only non-peer in whom such concerns can be confided. It may be especially difficult for the supervisee, moving between academic student and psychotherapy trainee roles, to stop thinking like a student getting a grade and think instead like a person in development. Therefore an additional task of the supervisor is to offer a place to talk about personal reactions not only to clients, but to graduate school and the rest of life. Faculty can also emphasize the listening component of mentoring. An faculty member or advisor should not be a clinical supervisor or psychotherapist to the student, but some of the functions do overlap. Providing an open ear on the academic side of training can help students experience a consistent environment as they struggle with professional identity development and its personal aspects. Both clinical supervisors and academic advisors can help prepare psychotherapy trainees to be open to exploration of their personal reactions to clients, by normalizing personal reactions and by attending carefully to the impact of evaluation. Graduate school is of necessity a trying time, but it can also provide support in keeping with its challenges.

Implications for the Practice of Psychotherapy

The data suggest several avenues to becoming a more effective individual therapist. First we will examine the guiding ideals of the therapist who wishes to manage and use personal reactivity in the service of therapy.
First, it appears that several theoretical orientations friendly to the notion of reactivity management were represented among the participants: humanistic, psychodynamic/object relations, and gestalt. Training received in these traditions seems to have enhanced the therapists’ predisposition toward using self as an instrument in therapy, toward believing that the psychological well-being of the therapist is highly relevant to his or her effectiveness, toward examining their reactivity to avoid imposing it, and toward using it to understand the client and the therapy relationship. Whether or not training in these specific theoretical orientations is more conducive to such practices and beliefs than other training is irrelevant. The point seems to be that any training that enhances or helps develop such predispositions allows the therapist to more effectively manage reactivity for the benefit of the client.

Two activities, reflection and consultation, seem to be important for developing the self-awareness needed to put the above values and beliefs into effect. The two activities are related and form a continuum. In fact one could argue, from within an object relations perspective, that reflection is a kind of internalized consultation. Participants in this study were about evenly divided on whether they made use of consultation. In some cases consultation appears to have played a crucial role in redirecting therapists.

One may analyze or synthesize human needs and related emotions in any number of ways. Empirical approaches like the CCRT will tend toward multiplicity and disorganization, theory-driven approaches like object relations will tend toward reduction and coherence. In the process of discovering an emotion and a related need, it is doubtful that any cognitive “top-down” approach will be as useful as simply asking one’s self. Perhaps the main benefit of taxonomies is to give us permission to have needs and related emotions, to make our reactivity understandable and part of the human condition, so that we may feel free to engage in reflection.
Some therapists participated in ongoing consultation that made it easier to bring up cases involving reactivity when it arose. Consultation provided a number of benefits discussed in Chapter IV. Willingness to seek consultation seems to signal the same lack of defensiveness that allows therapists to be alert for personal reactions in the first place. Such awareness can also be fostered through informal contacts among therapists.

The Wounded Healer

One implication of the grounded theory is that wounded healers really do help others heal through awareness of their own wounds. Logically, a healer must be able to avoid acting out psychological wounds with clients, or if they are acted out, they must be subjected to awareness and transformation before they cause too much damage to the psychotherapy relationship or the client. In some cases the therapist’s mistakes result in greater contact between therapist and client. There is an engagement between two humans acknowledging human frailty that in the long run results in greater intimacy. Or in the words of Jung (1963/1989): “When important matters are at stake, it makes all the difference whether the doctor sees himself as a part of the drama, or cloaks himself in his authority” (p. 133).

The emotional intimacy that can arise between therapist and client appears to have three roots: the sense of shared human vulnerability described above; the relative purity of therapeutic intention resulting from the therapist’s self-knowledge; and the possibility of deep and accurate empathy based on woundedness in common. “It is the woundedness of the healer which enables him or her to understand the patient and which informs the wise and healing action.” (Remen, May, Young, & Remen, 1985, p. 85).
The wounded healer is one who sees him- or herself as being in an ongoing process of development that is often catalyzed by interactions with clients – the “bilateral healing” model of Brothers and Lewinburg (1999). The decision to focus attention on one’s own woundedness leads the therapist to “a painful confrontation with his own problems and weaknesses, and ultimately to self-knowledge… the end result is a clearer perception of his ambitions and needs and their relationship to the task at hand. He [sic] can approach others with honesty, compassion and humility, knowing that he is motivated by genuine concern, not some ulterior motive” (Maeder, 1989, p. 77). As Hayes described, citing Whan (1987), the therapist must own the dual possibility of being both the wounded and the healer; otherwise the client assumes the full burden of being the wounded one and does not have access within the therapy relationship to his or her own healing capacities. Further, the therapist can be an example to the client of someone who makes the goal of mental health more accessible as a process rather than a distant goal, as Therapist 1 pointed out: “I cannot help but think that her ability to work and change something about herself also came… [because] I believe she experienced my change.”

It can be challenging for relatively inexperienced psychotherapists to accept such an ideal, when there is so much to prove in terms of one’s competence, both to one’s self and others, including peers, authorities, and the clients themselves. The dictum “Do no harm” can weigh too heavily on therapists who have not yet absorbed the ambiguity, open-endedness, and dialectical nature of psychotherapy.

The wounded healer is a far cry from Freud’s ideal of the thoroughly analyzed psychoanalyst (1959a), who, if betraying any wounds, demonstrates a need for further analysis. Freud’s ideal has been presented in many reviews, including Chapter II of this study, as a starting point from which totalistic and intersubjective approaches evolved; however, Freud himself may
not have been entirely dogmatic, indicating in the same lecture that analysts should engage in ongoing self-awareness and analysis in the course of working with their patients. The distinction between classical and later views of countertransference seems to hinge more on what to do with such awareness: the classical analyst strives continually for a technically neutral position devoid of reactivity; the intersubjective therapist has more options: to contain, transcend, disclose, explore with the client, and/or judiciously act on reactions and their motivating needs. There seems to be a varying range of recognition of these options among the twelve therapists who participated in this study, and a shared belief that vulnerability to reactivity is normal and a potential source of therapeutic sensitivity and utility. As such these therapists reflect historical shifts in thinking about countertransference and the person of the therapist, best synthesized under the concepts of intersubjectivity and the wounded healer.

The greater range of options in responding to reactivity requires greater responsibility of therapists to clarify the boundaries between use and abuse. Otherwise, the concept of the wounded healer becomes a mockery of itself and paints the picture of a therapist seeking salve for their psychological wounds through clients without regard to the therapeutic consequences. At what point is a wound simply a wound that inflicts itself rather than presenting opportunities for growth in both therapist and client? This is perhaps a difficult if not impossible question to ask the data from the twelve interviews, because naturally the therapists here interviewed are motivated to perceive the management of their reactivity in positive terms. Further, clients are motivated to please and even protect their therapists, and may avoid disclosing or displaying ways in which their therapists have inadvertently harmed them. I would suspect that in the context of these generally successful therapies, judged by client functioning in and out of
sessions as well as successful terminations or impasse resolutions, any wounding that occurred would have been minor and transitory. But one cannot be sure.

The double bind of wounding so familiar to therapists working with adult children of dysfunctional families – “I will wound you, then prevent you from naming the wound or escaping the wound” – is the converse of the paradoxical process of healing described by some of the therapists in this study. A permissive atmosphere of interpersonal and intrapsychic exploration characterized by valuing contact and empathetic understanding helps to heal psychological wounds, precisely because these wounds are the consequence of earlier relationships in which the client was not treated with empathy or made to feel valued.

The metaphor of wounding bears closer examination in order to avoid any mystification. A psychological wound could be described as a process that has become a structure, a patterned interaction characterized by damaging contact or lack of contact. One can surmise that the varieties of wounding reflect the same defensive interpersonal stances noted in clients and therapists in Chapter V. A client may have experienced victimization by an aggressor, abandonment, or a violation of boundaries in the form of enmeshment, including emotional or physical incest. Just as valuing contact or the holding environment can be internalized and transferred from, say, supervisor to therapist to client, the wounding interaction can also be internalized and transferred to the therapy relationship, by either party, for good or ill. It is in the therapy relationship that the psychological wound becomes available for a corrective experience. Therapists can be alert to their own histories of psychological wounding and their vulnerability to the particular varieties that their different clients may enact in the therapy relationship.

Hayes (2002) describes how he attends to the images, sensations and feelings arising from the reservoir of his personal history as he listens to his clients. He warns of the danger of
using experiences that are “open wounds” and advocates checking one’s level of emotional arousal to assure that an unmet personal need is not going to send one away from, rather than toward, connection with and understanding of the client. At the same time, he states “I do not think that complete problem resolution is either possible or essential; to help, the therapist needs to be only a step, not a mile, ahead of the client in the healing process” (p. 97).

Two further aspect of psychological wounding are relevant to recommendations for practice. The first is the way in which internalized wounding interactions affect the client’s and the therapist’s relationships with themselves. As we suffer from wounding interactions, we also try to make sense of them, and as developing people our meaning-making affects how we view ourselves, and consequently how we treat ourselves. Thus the value of projective identification, which may show us two faces of the wounded identity: what our reactivity (thoughts, feelings and behaviors) toward our clients tells us about how they view and treat themselves, and what our reactivity tells us about how we view and treat ourselves. Freud’s (1912/1957) metaphor of the direct telephone connection between the unconscious of therapist and client predicted this entire development of intersubjectivity.

The other aspect of psychological wounding that emerges from the interviews is its layered nature, due to defenses that both therapists and clients use to avoid experiencing wounding. Therapist and client may not be able to help unconsciously colluding in such defenses, because defenses usually operate outside of awareness. Once they are examined they tend not to work as well. Thus it is important for therapists of all experience levels to approach their ability to manage reactivity with some humility, and with the recognition that exercises in reflection may have limited utility because they do not include the working through of defenses and underlying wounding that can occur in therapists’ own therapy or other relationships. One
exception may be a contemplative practice like *tonglen*, which provides an empathic holding
environment and emphasis on self-awareness similar to the therapy relationship.

**Empathy**

According to the grounded theory, empathy is a fundamental of reactivity management. Empathy is one of the necessary conditions of therapy (Rogers, 1951) and particularly the means to bring to light and dissolve mutual reactivity cycles, as can be seen from the accounts of several therapists. Without genuine empathy, no amount of technical skill can bring about substantive or enduring change for those psychotherapy clients whose problems are rooted at least in part in empathic failures, as described above in the section on the wounded healer.

But how does the aspiring therapist develop empathic ability? Is it a trait or a state? Can it be taught or does it have to be caught? Several of the therapists interviewed illuminate the process of developing empathy for particular clients, but not in general. Obstacles to empathy appear to be those aspects of clients’ behavior, personality, or appearance that resonate with aspects therapists have found objectionable in themselves or important people in their lives. To develop empathy, therapists are thus challenged to accept a broader range of experience in themselves or others. Obstacles also include defensive reactions designed to protect the self from a perceived threat. Once the threat is perceived as an expression of clients’ own needs, the defensive reaction is no longer required. Empathy is also nourished through receiving empathy from others and offering it to one’s self.

The most immediate stimulus for empathy is knowledge of the client as a suffering human being. This idea may lessen the anxiety of relatively inexperienced psychotherapists who push themselves to demonstrate empathy, making a show of warmth that clients rightly suspect
is forced. This outward push leaves little room to take in the private world of the client, which incites empathy. So, in answer to the question of state versus trait, empathy appears to be a state akin to knowing. It is in fact the relationship between knower and known, but it does require the therapist to be ready and willing to know the client. Empathy can therefore not be taught, but that which facilitates knowing another person can: which questions elicit richer, more honest responses; which attitudes promote receptivity; which theoretical frameworks offer a window into the client’s world.

Self-care

One element that appears to nourish the development and maintenance of empathy is self-care in a variety of forms. Self-care seems to involve several components: time, movement/stillness, distraction (complementary to the focus involved in reflection and consultation), and connectedness/separateness. Different therapists have different needs and there is clearly no universal formula for self-care. The time component does seem universal in that self-care requires setting aside time that might have been spent on other priorities. The time component also implies a certain stance toward self-as-therapist as having needs and limitations. Perhaps those therapists who are good at caring for themselves have a greater level of acceptance of their limits, and have let go of the ideal of the therapist as continually loving and giving. This ideal seems oppressive and may have an insidious effect on therapy, in that clients may not accept their own human limits if they do not see their therapists as limited. The capacity for self-care thus is tied into the concepts of empathy and the wounded healer.

Movement/stillness is represented by exercise, yoga, napping and meditation. Each activity replenishes and/or releases energy, while also altering consciousness. One might see
such activities as releasing the therapist from a bind through a direct shift in consciousness, rather than one mediated by language, as in reflection and consultation. Activities such as exercise, sleep, yoga and meditation allow one to detach from a goal-oriented state and be in the moment.

Distraction is represented by non-psychological reading and deliberately not thinking about a client much in between sessions. Some therapists mentioned specific boundaries around reflection times. The presence of such a form of self-care indicates that an important activity may be ignored in training programs, which tend to model an ideal of being a continuous student in the sheer volume of their requirements. Graduate students know that they need breaks, but may struggle with guilt over taking them, rather than seeing them as integral to good practice. Although training programs may give lip service to self-care and maintaining other interests, they do not require these as they require other activities, thus sending conflicting messages.

The component of connectedness/separateness is represented by the safety and affirmation gained from family and colleagues and the need for time alone. The practice of psychotherapy can be both intensely interpersonal and intensely isolating, in that the focus is on the client’s experience. Therapists can therefore feel conflicting needs to get away from others and receive affirmation of their experience from others. Balancing these needs can be a challenge. Attention to the contact-withdrawal cycle in a felt sense can help practicing therapists to avoid burnout and be available for contact with clients when needed.

Summary of Grounded Theory Implications

What can be concluded about the development of a greater capacity to manage and make use of reactivity? The therapist stands at the nexus of human needs and professional ideals.
These intersect to the extent that professional ideals encompass self-awareness and compassion for both self and client. To satisfy his or her human needs, the therapist must cultivate those relationships and practices that both replenish the self and make the achievement of therapeutic ideals like self-awareness and compassion possible. Very often the same relationships and practices can help with both. Training programs can emphasize those theoretical perspectives that honor the therapist’s human needs while encouraging awareness of them and their influence on the therapy relationship. Further, training programs can practice what they preach by encouraging balanced lives and by offering affirming supervisory and mentoring relationships. The primary responsibility for self-care and self-development lies, however, with the therapist.
Chapter XII

AUDIT OF GROUNDED THEORY DEVELOPMENT

Introduction

This chapter provides an account of the decision-making process and reasoning behind decisions made in the course of data analysis. Analytical tasks requiring decisions included: coping with investigator and participant bias; delineating the conceptual boundaries of the categories; shifting from Consensual Qualitative Research to grounded theory while incorporating work already completed; determining relationships among and within categories; choosing and naming a core category; determining saturation of theory and its fit with data; developing flowcharts; and applying evaluation criteria to the theory as a whole. Although these tasks are in somewhat chronological order, they were not strictly sequential, but overlapped and doubled back as each affected others. Any of these tasks could be subject to feedback from the participants and the thesis advisor; this feedback had to either be rejected with a clear rationale, or integrated into the theory. Limitations to the study are also discussed. Finally, some reflections are offered on the investigator's personal and professional development resulting from engagement in the research process.

Managing Investigator and Participant Bias

The investigator identified the thesis advisor’s theory of countertransference (Hayes, 1995), consisting of origins, triggers, manifestations, effects, and management, as a potential bias against identifying emergent categories. A number of major categories did appear to fit the
elements of this theory, and each was questioned to determine whether it actually fit well. As a result, several differences emerged, described below under Development of Categories.

In writing this chapter I reviewed tentative theories I’d developed throughout the doctoral program, and came upon examples with close relationships to the grounded theory:

(1) Although the client’s cyclical maladaptive pattern (CMP: Levenson, 1995) pulls on anyone, the pull will be stronger for some therapists than for others, depending on the CMP of the therapist. Client CMPs can be grouped according to how they elicit complementary CMPs in the therapist.

(2) Countertransference management equals growth in the therapist. Countertransference equals interference, originating at least to some extent in the conditioning of the therapist, in the three necessary conditions for growth in the client:

Unconditional positive regard
Empathy
Authenticity

(3) Countertransference management depends on issue resolution. Issue resolution can be operationalized as ability to generate a narrative about issue with the following identified:

1) Self as agent (in present, maybe victim in past)
2) Identification of issue in interpersonal terms
3) Identification of issue in intrapersonal terms
4) Description of how inter- and intra- relate
5) Motivation to resolve issue
6) Motivation to repeat issue
7) Alternate thoughts and behaviors
8) Benefit to client of CT management/negative impact of no change
9) Diminished need to monitor self re issue
10) How to use wounds for healing client

These examples are of interest because they demonstrate that certain themes raised by the therapists in this study had been present for me in the two years prior, as I had reflected on my own clinical experience and attempted to integrate experience and literature. One can view the correspondence between these early theories and the grounded theory as either evidence for the
trustworthiness of the grounded theory, or as evidence for the influence of preconceived ideas on my interpretations. More triangulation (Lincoln & Guba, 1985) beyond the feedback given by the auditor and the research participants would have helped resolve this question. The readers are left to provide this triangulation themselves, by reflecting on their own clinical experience.

The investigator as well as the original research team members also wrote out assumptions about countertransference management. Due to the fact that the research team approach did not last into theory development, team members’ assumptions do not have much bearing on the ultimate outcome, with one exception: Randy Patterson offered the idea that the origins of countertransference could reside in the therapy relationship itself. This assumption found its way into the decision to consider the therapist’s and client’s contributions to reactivity together, within the same category. When it became clear that the therapists were often describing interactions of therapist and client that would have been much less comprehensible if treated separately, Randy’s assumption influenced her part in the debate on category development and helped finalize the decision.

The investigator’s assumptions were written after the literature review and before the interviewing, and consisted of a series of steps in the countertransference management process:

1. Client history leads to symptoms that challenge the therapist
2. The therapist has needs grounded in his/her history
3. When client and therapist needs are expressed in behavior, they conflict
4. This conflict affects the therapy relationship
5. The therapist must first identify the challenge presented by the client
6. The therapist must next assess his/her response to this challenge
7. The response to the challenge is aimed at need resolution
8. The therapist must find a new response also aimed at need resolution

The focus on needs clearly carried through to theory development, and may have been imposed on the data to the extent that the therapists rarely defined their needs in reified form, but implied
them through narratives about being threatened or gratified in particular ways. However, this
difference can be explained in the formal difference between a story and a theory. A theory must
define constructs and their relationships; a narrative can demonstrate these constructs and
relationships through action. A parable contains both: the story, and the moral of the story. Some
of the therapists who seemed more interested in stepping back and conceptualizing told parable-
like stories – Therapist 9 seems to be the best example – and others were less systematic in
highlighting constructs and their relationships. Yet the concrete narratives themselves contained
similar structures that pointed to the human needs of the therapist as central characters.

The purpose of writing out assumptions is to bracket them, i.e. to reduce their influence
by making them conscious. When identifying possible meanings in the data, the investigator can
ask, “Am I seeing this because I already expect it? If I were not seeing this, what else would I be
seeing?” There has been a controversy within grounded theory writings (Dey, 1999) on the pros
and cons of being familiar with existing thought about a subject before studying it. One can
certainly be more attached to some interpretations than to others, regardless of one’s knowledge.

Therefore the key is not to avoid pre-existing ideas, but to monitor one’s attachment to
them in the face of data that may be interpreted in other ways. In my own case, there was
certainly a ready agreement with therapists who emphasized the importance of emotionally lived
experience, both the client’s and the therapist’s, to client change in therapy. This prejudice lies at
the heart of my own practice of psychotherapy – increasingly so over the course of time that this
study was conducted – and is therefore quite difficult to bracket. Instead, I can only own this
prejudice as permeating the interpretation of the data and the development of the grounded
theory.
Participating therapists were asked, in the process of responding to the interview questions, to say quite a lot about their theoretical assumptions, both explicitly and implicitly. These assumptions influence both their accounts of reactivity management, and the actual management of reactivity. For example, in the interview Therapist 3 framed her work with her dissociative client in terms of contact, a concept central to gestalt psychology. Not only did she convey this interpretive slant to the investigator, she also actively used the idea of contact as a cornerstone in her work with the client. Therapy is a theory-laden activity: the therapist is constantly reinforcing or revising a theory about the client, what causes the client to suffer and what will liberate the client. There is no escape from this theorizing without negating the entire cognitive side of the therapist’s work. The therapists as well as the investigator interpreted their experiences.

Development of Categories

Categories were developed consensually with a small team of graduate students (the investigator and two fellow students), with category names, definitions, decision rules for assignment of data to categories, and actual assignment audited by the investigator’s thesis advisor. Revisions to categories of meaning occurred as a result of individual reflection, discussion with the research team, and interchanges with the auditor.

Although the Hayes (1995) theory of countertransference was not an explicit starting point for category development, differences between this theory and the final boundaries of major categories are instructive of the category development process. Origins and Triggers were combined into Causes, in order to capture the highly interactive nature of these two sources of reactivity. Manifestations were changed to Personal Reactions, so that cognitive, emotional, and
behavioral components of reactivity could all be considered together. The category of Management Facilitators was distinguished from Management itself, so that the influence of factors existing prior to the therapy relationship could be understood. Another addition was the category of Management Results, again bringing together therapist and client by including their development based on the therapist’s management and/or use of reactivity.

The following document (Figure 14) may be compared to the definitions embedded in the data analysis chapters (see below) and exemplifies the evolution of definitions that occurred. Some of this evolution is covered under Integrating Auditor Feedback, and some under Conceptual Deepening. The last four categories, Interventions, Context, Non-CT Reaction, and Other were eliminated from the grounded theory, which permits one to leave out data that are determined to be outside the conceptual boundary of the phenomenon being studied. Some of the data belonging to Interventions and Context remained relevant to the narrative summaries of the cases in terms of setting the scene and suggesting other ways in which clients were assisted. When therapeutic interventions were made possible by or were aspects of reactivity management, they were included within the core category of management. Other therapeutic interventions appeared to bear no causal relationship to the reactivity management process.

Figure 14: Intermediate version of category definitions

COUNTERTRANSFERENCE MANAGEMENT: DEFINITIONS OF DOMAINS

Alan Baehr, Chad Johnson, Randy Patterson 11/8/01, revised 12/13/01, 2/10/02

Core Concept around which domains are centered:
COUNTERTRANSFERENCE (CT)
The therapist’s response to the client together with the causes and effects of this response, when this response is less than optimal due in some part to factors the therapist brings to the therapy independent of the client.

ORIGINS
Any aspect of the client, therapy, or therapist that, in the therapist’s view, has contributed to the manifestation of CT. Therapist thoughts or feelings that contribute to manifestation behaviors are still part of the manifestation unless they are patterns of thought or feeling that preceded the therapy.
MANIFESTATION
Any thought, feeling, or behavior of the therapist that forms part of the CT.

MANIFESTATION EFFECTS
Any change in the client or the therapy relationship that in the therapist’s view is at least in part a result of CT manifestations.

MANAGEMENT
Any thought, feeling, or behavior of the therapist, in or out of therapy, that is intended to manage CT in a therapeutic manner.

MANAGEMENT RESULTS
Any change in the client or the therapy relationship that in the therapist’s view is at least in part a result of CT management.

MANAGEMENT FACILITATORS
Any aspect or activity of the client, therapy, or therapist that in the therapist’s view facilitates CT management. Should be a trait or pattern existing before the CT has manifested.

THERAPIST DEVELOPMENT
Any change in the therapist that in the therapist’s view is a result of working with this client, that endures beyond this therapy relationship, and that is seen by the therapist as positive.

CONTEXT
Any information about the client or the therapy that is helpful to understanding the case as a whole but is not a behavior that could be classified under another domain. May include client history, case conceptualization, frame of treatment, therapist history related to origins.

INTERVENTION
Any behavior on the part of the therapist intended to be therapeutic that is not limited to a manifestation or management of CT.

NON-CT REACTION
Any cognitive or affective response of the therapist to the client or therapy relationship that is not directly related to CT.

OTHER
Any text that does not fit into the above categories, including all interviewer comments unless they express the therapist’s view, based on confirmatory comments by the therapist.

The above schema of major categories is little more than a replication of Strauss and Corbin’s (1990) grounded theory paradigm, including a central phenomenon, causal conditions, strategies for action in relation to the central phenomenon, intervening conditions, and consequences of the strategies. It is in the subcategories that the conceptual richness, and the greatest risk of imposition of preconceived theory, exists. Some subcategories were descriptive and involved little inference, acting more as labels under which data could easily be gathered.
Such was the case with interpersonal history and interpersonal tendencies. Defining the variations among these did require conceptual thinking; in identifying dependency, avoidance and aggression as the three variants, along with their origins in interpersonal histories of loss, abandonment, and violation of boundaries, I relied upon whatever synthesis of interpersonal theory I had arrived at through past reading and reflection, but without applying any particular model. The threefold division help up well as I systematically related different components of reactivity, reactivity management, and management results.

The cognitive, emotional, and behavioral components of therapist reactions also required some abstraction from the data, because the therapists did not tend to make these distinctions formally – again the distinction between narrative form and theory form. Clearly, these distinctions reflect a Western world view in which they have meaning. However, this is hardly a criticism if the investigator, participants, and reader all share in these assumptions. One drawback might be the omission of the body from consideration. Certainly the body was not given prominence by most of the therapists, although some discussed visceral reactions and use of touch. The use of transcripts without the aid of videotape also reflects a focus on mind over body, on language over felt sense. If reactivity is initially unconscious then it may indeed be experienced primarily through the body, before it becomes invested with meaning. This omission is certainly worth pursuing in further study.

The provenance of the concept of psychological needs, one inferential step removed from some of the therapists’ accounts, was discussed above. Other concepts that relied on some abstract reasoning from the data and use of existing theory were: psychological wounds; psychological defenses; transcendence versus containment; empathetic understanding; congruent empathy; valuing contact; the holding environment; and corrective experience.
The concepts of the wounded healer and psychological wounds arose from Therapist 7. The metaphor of the wound is discussed in Chapter XI. I was familiar with the wounded healer archetype from discussions with my advisor and previous reading, but had not thought to apply it until Therapist 7 made it explicit. I then sought to define what wounded healers do by comparing therapist narratives. Although I initially perceived a dramatic divide between the therapists, later I came to see the distinction as more subtle. For example, all of the therapists engaged in some use of self to understand and connect with their clients. Not all of them used their wounds directly in the therapy relationship, however: some did not describe woundedness playing any role, others used their wounds as ways to develop empathetic understanding. But four of the therapists (1, 7, 9 and 12) from their descriptions and from their impassioned manner of describing, clearly brought their woundedness into the room, not in a confessional mode, but in the sense of embodying a fellow wounded human being. It may have been the way in which these therapists talked, as much as what they said, that led me to develop a unique definition of wounded healer, one that seems to epitomize the intersubjective approach evolving in the countertransference literature.

Psychological defenses, congruent empathy, valuing contact, the holding environment, and corrective experience were all identified by more than one therapist. My work was then to see how well each concept applied across therapists, and to try to account for the differences.

Finally, there is the distinction between transcending and containing reactivity. This is another subtle distinction, like the difference between wounded healers and relational experts: more is shared than is divergent. My own self-observation in struggling with reactivity played a role in defining transcendence, because I noted that it was easy to attain a degree of intellectual detachment from a reaction without actually resolving the issue. Still, transcendence seemed to
be the best term for a shift in relationship with a psychological wound or need. Empathy for self and valuing contact with self have allowed me to have the wound or need, rather than the wound or need possessing me. This is quite different from either achieving a false state of healing through heady transcendence, or setting a need or wound aside in order to make contact with another person, i.e. containment. In judging which therapists seemed to contain reactions and which seemed to transcend them, I paid attention to whether their narrative included a shift toward how they related to themselves, versus a shift in how they saw their reactivity.

From CQR to Grounded Theory

As described in Chapter III, this study was initially designed as Consensual Qualitative Research. The following is the majority of the letter (with summary of dissertation topic and progress on data analysis omitted) sent to my committee on June 24, 2003, arguing for the shift to grounded theory:

Based on my experience to date, if I continue to adhere to the CQR guidelines then the rest of the research process may be disjointed, drawn out, and possibly grind to a complete halt. My advisor, Jeff Hayes, and I have discussed this situation and see an opportunity to shift direction without reducing the trustworthiness of the method. In fact, what we are proposing in many ways enhances the appropriateness of the method for answering the research question.

Grounded Theory specifies a coding paradigm of a Central Phenomenon (in this case, Countertransference), Causal Conditions, Strategies for Coping with the phenomenon, Context and Intervening Conditions that influence the strategies, and Consequences or outcomes of the strategies. This paradigm maps beautifully onto the domains already developed through consensus. Jeff’s original concern, in being most familiar with CQR, was that Grounded Theory might lack the rigor introduced by consensus methods for reducing researcher bias through multiple perspectives. We believe, however, that the following approach will respond to this concern.

1) I will retain the domains and meaning unit assignments to these domains (although at any stage of analysis, meaning units may be reassigned and domains may be split, merged or redefined as the data appears to demand.) These domains have been developed through CQR and iterative return to the data seeking counterexamples, thus providing a more trustworthy outcome than grounded theory alone.

2) I will develop subcategories within the domains, following grounded theory, and relying on the core ideas from the 3 interviews [already coded using CQR] as a means of identifying these subcategories. The concise nature of the core ideas will assist in seeing the commonalities and differences among them. An example might be finding that both countertransference and strategies to manage it fall into cognitive, affective, and behavioral subcategories. Because I may have a
theoretical bias toward perceiving such a division, I will search for counterexamples in the rest of
the interviews and revise the subcategories as needed.

3) Following CQR methods, my auditor will review these subcategories and suggest whether other
breakdowns may fit the data better. We will discuss these issues until reaching a consensus.

4) Based on the 3 interviews from step 2, narrative summaries of each interview’s account of
countertransference management will be developed, using the domains and subcategories as
organizational reference points. This step is common to both CQR and grounded theory.

5) Following grounded theory methods, I will develop a set of propositions and flow chart
describing the process of countertransference management for these 3 interviews. I will then select
another interview at random and test the propositions and flow chart against it, and so on, until all
9 remaining interviews are accounted for within the theory. It will be important to return to
already incorporated interviews when further ones raise questions, leaving a memo trail along the
way.

6) Following CQR methods, the auditor will review the fit of the theory to the data and to the
narrative summaries. Following both CQR and grounded theory, the participants will all be
asked to do so as well. Feedback will be incorporated.

Three questions come to mind regarding this change: 1. Does eliminating core idea development for the
remaining 9 interviews pose a problem? 2. Are safeguards against researcher bias adequate compared to
CQR? 3. Is the data set adequate to arrive at saturation, i.e. the point at which new data does not add to the
theory?

1. In terms of the first concern, the purpose of core idea development is to facilitate a cross-analysis or
search for themes and variations across interviews in the content within domains. This is parallel to
subcategory development in Grounded Theory, which does not use the intermediary step of boiling down
meaning units into core ideas, but goes directly to themes within domains (e.g. transference as a
subcategory within the domain of Countertransference Causes). In subcategory development, abstraction of
the essence of the meaning and cross-analysis are both implicit. Retention of the full richness of the data
rather than working directly only with core ideas will allow for more nuanced subcategory development.
For example, a meaning unit may express the shift from an awareness of emotion toward a
conceptualization of that emotion. On the other hand, not having core ideas ready to hand may make it
harder to see commonalities across interviews. If this happens, then core ideas could be developed with the
auditor providing a check on researcher bias.

2. The more perspectives sought and incorporated, the less individual bias determines theory development.
The disadvantage of auditing and member-checking (seeking feedback from interviewees) is that the theory
is being presented for feedback, rather than these other perspective-holders working directly from data to
arrive at their own theories. However, the data themselves act as checks on researcher bias, by asserting
narratives that may fit poorly with theory and necessitate its revision (see step 5 above). Grounded theory
calls this the constant comparative method. There is no such iterative approach in CQR, except for the
option of holding off a minority of the interviews to check the cross-analysis against, but that’s a single
iteration as opposed to 9 iterations in step 3. I’ve also already written out my anticipated propositions, and
can bracket this by an attitude of letting the data speak, and then actively looking to disconfirm my
anticipations. The addition of the auditor to the grounded theory method and of the consensus approach to
domain/category development actually makes the method more trustworthy than grounded theory alone.
Extensive memoing can also attest to trustworthiness, allowing the reader to see the care with which truth is
sought.

3. It is entirely possible that the last few interviews considered will continue to elaborate on the theory of
countertransference management, implying that more interviews could provide further elaboration.
However, there are two logical flaws in the concept of saturation: no matter how much the data begin to
repeat themselves, there is no guarantee that another case would not result in a major revision or extension of the theory. In fact, one study always calls for a further one, and theory elaboration and revision is the essence of science as a dialogue (Kuhn). Secondly, once a theory is developed to a certain point it may saturate the researcher, so that new data would be at pains to disconfirm it. There is no way to tell if the data have stopped providing fresh input, or if the researcher has stopped seeing the data from a fresh perspective.

OK, so I am asking for each of you to say “Yes, that sounds like a sound rationale. Go ahead and revise Chapter 3 and proceed with the data analysis.” If you are not comfortable saying this, please let me know why as soon as you possibly can. Or if you do not understand any of this, please ask for clarification. I would be happy to discuss this with you via email, phone, or face to face, but as you can guess I am very eager to move forward.

I met with one committee member to review my thinking; all of the committee members approved the change on the strength of the letter, the thinking behind it, and/or their trust in the thesis advisor. My personal reaction was elation, not only at making the product more achievable, but at being able to use a method that fit my intense interest in theory-building and would allow the participating therapists’ wisdom to come through in all its depth.

Conceptual Deepening

Theory development was achieved in three primary ways: developing tables, developing flowcharts, and writing. The tables helped to identify subcategories, such as the pervasive theme of avoidance, aggression, and dependency. The flowcharts helped map out themes and variations in processes. Writing helped to deepen understanding of both content and process, and to expose and respond to assumptions. The following series of memos is illustrative of this conceptual deepening.

1. MEMO 6/27/03  Grounded Theory based on Interviews 1, 2 and 4

Central Phenomenon: Countertransference (CT)

Causal Conditions:
Causes in therapist
Causes in client
Causes in interaction of therapist and client
Strategies:
- Ways of becoming aware of CT
- Ways of understanding CT

Strategies continued:
- Ways of avoiding acting out CT
- Ways of transcending CT
- Ways of using CT to understand client
- Ways of using CT to help client understand self
- Ways of maintaining change

Intervening Conditions:
- CT Management Facilitators: therapist traits
- CT Management Facilitators: therapist practices
- CT Management Facilitators: client traits
- Changes in client level of functioning unrelated to treatment
- Quality of client’s support system

Consequences:
- Changes in therapy relationship
- Client outcomes on treatment goals
- Quality of termination
- Therapist personal growth
- Therapist professional growth

This first attempt at a grounded theory based on three interviews reads more like a list and does not describe process, i.e. causal connections among categories. This list approach is more akin to results from a CQR study, and highlights the advantages of grounded theory. At the same time, the subcategories remained fairly stable from then until the final grounded theory, indicating that the addition of other interviews did not radically alter the basic themes.

2. MEMO 7/1/03   core category

Started out thinking core was CT management, but that may be the strategy for coping WITH the core experience. If it’s management, then some of the categories that have emerged already – causes, manifestations – would have to be related secondarily to CT, in turn secondarily to management. It seems more straightforward to look at CT as the core. It’s the experience that mobilizes the coping.

Now CT can stand for the therapist’s conscious reaction – the labeling of emotion, as in “I’m angry” or the anger itself, or the acting out of the anger, or the whole bag including the origin of the anger in the therapist, in the client, in the interaction. To describe a process we have to break it down and decide which part of CT is core. Nominees are: the emotion itself, or the motivating belief leading to the emotion. It seems that some examples of CT are more the emotion itself, some stand for underlying issues, some stand for defensive reactions, some stand for roles taken, and some are about participation with client in the client’s stuckness. In most cases, there was a stuck pattern of relating. In some cases, the therapist could draw on previous awareness and not act out a stuck pattern. In some cases, the underlying issue wasn’t clear or perhaps wasn’t there, in that the pull was all from the client in the therapist’s view. So the most common core would be…
A challenge from the client that made the therapist emotionally charged, or, in shorthand:

**Emotionally challenging client behavior, possibly along with therapist tendency/trait/need/issue**

This memo reflects my commitment to avoid assuming that the core category should be reactivity management (at that time still labeled “countertransference” or “CT” management). Ultimately the thinking in this memo was abandoned because the most differentiated category, and the one to which most of the interview questions were addressed, was reactivity management. On the other hand, the need to include both therapist and client factors remained.

3. MEMO 7/19/03  relationship between interventions and reactivity management

- Counter-therapeutic tendencies/actions are transformed into effective interventions. These complement/are integrated into existing interventions
- Both effective interventions and awareness of counter-therapeutic tendencies/actions stem from a vision of good therapy: goals, methods, therapy relationship
- Interventions can be “correct” – fit into vision of good therapy – but be ineffective/harmful when not congruent with therapist’s emotional reactivity
- Acting out of counter-therapeutic tendencies can lead to awareness/transformation and ultimately be therapeutic.
- Interventions can combine reactivity management and understanding of therapy as sources

This memo reflects thinking that withstood the test of time; each proposition found its way into the final theory. In the original process of developing categories, many meaning units were assigned to the *Interventions* category. In CQR all categories would have been retained, but in grounded theory only those categories are kept that are relevant to the phenomenon being studied. Many interventions described by therapists were part of a description of the overall therapy relationship and appeared to have little relationship with reactivity management; others bore the kind of relationships described in the memo.
4. MEMO 8/2/03  optimal reactivity management process

There is an optimal management process that incorporates all elements, then suboptimal ones limited by the level of depth with which therapist works with client. In some cases the deeper steps are implicit and can be logically derived from context, or have already occurred prior to the therapy work and are compressed in language.

Elements:
- Genetic Understanding [of Causes of Reactivity]
- Compassion for Self/Other
- Use of Self
- Containment of Experience for Self/Other
- Use of Life Wisdom for Self/Other

This memo begins to outline the distinction between relational experts and wounded healers, and reveals a bias on my part toward humanistic therapy. In recognizing that bias I later abandoned the idea that a single, optimal reactivity management process exists, instead trying to identify the types of clients or client issues that appear to call for “deeper steps.” I also tried to avoid value-laden terms like “deeper.”

5. MEMO 8/2/03  causes of reactivity

Emotional Reactivity in therapist and client has both etiology and teleology. The core emotional-relational experience reflects basic needs that both generate reactivity and seek fulfillment. This search ultimately leads to a rejection of self-defeating, reactive means of attempting fulfillment. So far these needs are identified: mastery, safety, being known, being respected.

This memo also stems from a pre-existing idea, gathered at some point from Jung’s writing. In my memory Jung distinguished himself from Freud in his view of symptoms, in that they pointed not only backward to their psychogenesis, but forward to their resolution.

Symptoms were communications from the self that a need for individuation required a response. Although none of the therapists made such a view explicit, I decided to retain my interpretation without the Jungian trappings, because the centrality of psychological needs in the grounded theory requires as an axiom that needs press for resolution in some way. At the same time, resolution cannot narrowly be defined as wish fulfillment: in many cases clients did not get what they wanted, but learned to live with existential limits.
6. MEMO 9/14/03 consultation and comparison with therapeutic ideal

The process map of management is not going to be tightly controlled by “if-then” decision points, because there is a broader process of consultation or comparison that can occur through a number of means, and at a number of levels of awareness.

Variables:

Comparison:
- behavior to ideal
- emotion to ideal
- attention/cognition to ideal
- outcome to ideal

Exploration:
- In-session
- Out-of-session
- Past
- Present
- Alone
- With other(s)

Half of this memo was integrated into the theory, and half was rejected. The initial idea that reactivity management may take many pathways that are not absolutely determined by dichotomous choices became an important principle in elaborating the theory throughout the data analysis chapters while retaining the notion that therapy is an open, self-correcting system.

Comparisons to therapeutic ideals could not be found consistently in the data and was eliminated as an example of my own speculation. Types of exploration are represented in the data but are not meaningful ways of organizing the data: they did not seem to make a difference in the process.

7. MEMO 10/3/03 kinesthetic vocabulary of reactivity and management

One easy way to conceptualize the balance of therapist and client contributions to personal reactions is pull and push. There’s a kind of kinesthetic vocabulary here of holding, touching, being pulled, being pushed, leaning away, leaning in, sitting upright, etc. Also grounding, centering, balancing.

This memo eventually became a paragraph in the body of the theory. It was not integral to understanding the theory, but is suggestive of ways in which therapists may conceptualize their experiences while staying close to the felt experience. Kinesthetic representations suggested
to me that neither the therapy work nor the management of reactivity is happening at an overly intellectualized level, and added additional weight to the idea that the therapists participating in this study were successful in managing their reactivity in part because they became aware and sought to make use of their emotional reactions.

8. MEMO 10/26/03 therapeutic striving

Process of management is implicitly governed by a striving for something: wholeness, connection, health, relief of suffering, and this striving is sometimes wholly on behalf of the client, sometimes for both therapist and client. The client’s own striving also facilitates. This striving is also reflected in the therapist’s philosophy of treatment and/or life, which both guides decisions implicitly and sometimes plays a role as a touchstone, a form of self-talk.

This memo was meant to identify a therapist and client motivation counterbalancing the mere search for wish fulfillment based on unmet psychological needs. In the end I decided that needs include such striving, and that professional responsiveness and personal growth worked in concert for many of the therapists once they were able to move past defensive stances toward their own needs. Philosophy of life did not come into play explicitly with a few exceptions, and it felt as though I was imposing that idea. However, it would be interesting to explore how therapists try to live their personal lives and the overlap with their therapeutic approach.

Another method of conceptual deepening was the use of tables. I developed tables using various subcategories to see how the different therapists fit, and to relate specific text with categories and subcategories. These tables were used to categorize causes of reactivity, personal reactions, effects of reactions, management facilitators, reactivity management, and management results. Tables were also helpful in following themes across categories, especially to test the consistency of the avoidance-aggression-dependency subcategories and the types of needs and need conflicts underlying them.
Determining Saturation and Fit with Data

I developed the habit of periodically re-reading the transcripts of the interviews, or sections of them relevant to the area I was trying to understand. Each time I developed a specific theoretical idea, I would imagine each case and see how well it applied. At times this exercise would yield a more differentiated view of a particular phenomenon. For example, checking how well the role of the wounded healer fit different participants led to a greater understanding of how empathy differs depending on whether the therapist resonates with the client’s pain. I would also attempt to identify the therapist who least represented the views of the rest of the group, and see what differences emerged.

Another method of determining saturation and fit with data was the gradual synthesis of therapist narratives into a single flowchart, discussed below.

Developing Flowcharts

The process of developing and revising flowcharts of the grounded theory was very helpful in a number of ways. Placing categories and subcategories in spacial relationship to each other allowed me to think about their conceptual closeness or distance. Space limitations led me to explore whether certain pairs of subcategories should be collapsed into one. My interest in theoretical elegance also helped me identify parallel processes, such as therapist empathy for self and empathy for the client, or consultants providing a holding environment for therapists, which in turn helped the therapists provide a holding environment for their clients. Drawing arrows signifying causal connections among categories and subcategories allowed me to search for connections not yet identified (one of these was also suggested by the auditor).
Not all narratives achieved the same goodness of fit with the flowchart. Some of the relationships pictured there are more explicit with some therapists than with others. Issues of whether a relationship is implied or absent are addressed in the body of the data analysis—Chapters V through VIII. In applying theory to practice, the question may not be whether all the elements of the theory are required to manage personal reactions, but which ones under which circumstances. I was cautious not to develop any hard and fast conditions for different avenues of reactivity management, because the purpose of the grounded theory is to open up possibilities for therapists managing their reactivity, not close them off. Furthermore, the nature of theoretical sampling does not permit such inferences as, “When the therapist enacts reactivity in the therapy relationship, consultation with colleagues is better than reflection” or “Personal origins of reactivity should be disclosed to clients who have minimal capacity for contact, in order to develop trust.” One advantage of a body of clinical wisdom that is made up of options rather than dictums, is its openness to further differentiation. In other words, theory is a good servant but a terrible master.

In addition to feedback on clarity and some definitional issues, the auditor offered several comments on possible relationships among subcategories in the flowchart. First, he asked, “ Doesn’t the therapist’s personal history affect their perceptions of similar the client is to self and others? ” This made theoretical sense and was also borne out in the interviews, so I added this connection.

The auditor also wondered about the relationships among several management facilitators: therapist commitment to the client, therapist traits, training, and theory. In that version of the flowchart, traits and commitment were placed together…partly to help avoid overwhelming the reader with separate boxes, partly because “traits” was a term inclusive of
attitudes. By the same token, training and theory were combined into one subcategory.
Commitment was ultimately taken out because it was not discussed directly by any of the therapists, although some speculative writing about it was retained for the sake of the reader’s own contemplation. However, traits and beliefs were placed together because they appeared to function in the same way, by giving therapists the wherewithal to confront their own reactivity. Training and theory were also perceived by the investigator to facilitate reactivity management in the same way, by providing a framework for empathetic understanding, empathy, and valuing contact. Even when training emphasized experience over theory, as with gestalt, the experiential component was grounded in a set of theoretical beliefs. Conversely, when therapists applied theory to their management of reactivity, the theory was congruent with their experience.

Identifying the Nature of the Core Category

This step was a culmination of immersion in the data; I deliberately held off on trying to define the essence of reactivity management until I had thoroughly explored and discussed all of the categories in the theory and their relationships. In identifying therapists’ reactivity management as the process of bringing therapist and client needs into conscious relationship with each other, I was trying to capture the common ground between wounded healers and relational experts. What seemed powerful here is the idea of needs being in relationship, without predetermining the nature of the relationship. As I explored this idea through writing about it, its appropriateness became more apparent. The idea of complementary empathic containment and connection directed both inward and outward flowed from reflection on the nature of contact in each therapy relationship.
Integrating Auditor Feedback

As mentioned previously, the author’s thesis advisor served as the auditor. Feedback was received through email exchanges, written comments on chapter drafts and flowcharts, and occasional face-to-face meetings. Feedback generally fell into three types: conceptual boundaries of categories; clarity of definitions of concepts and labels in flowcharts; possible overlooked causal connections; and possible overlooked subcategories. Suggestions regarding the flowchart were discussed above. The other suggestions relevant to theory development and trustworthiness were contained in email exchanges reproduced here, dovetailed with my responses:

8/13/03

**Jeff:** A couple of thoughts: Could a personal reaction be visceral? Empathy is not the only way that compassion can be expressed behaviorally.

**Alan:** Some therapists did mention having bodily sensations (5, 7 and 9 come to mind). These were associated with emotional states – guilt, dissociation from emotion, shame. So I wouldn’t necessarily separate sensation and emotion, unless the therapists did, but they didn’t. However I will include this dimension in the description. It was for therapist 7 the first signal that helped her understand her reactions.

I’m in the middle of sorting out what the therapists were saying about empathy and compassion and the relationship between the two. Therapist 9 used touch to make affirming contact. A number of therapists talked about their clients’ need to be seen, to have their experience known by another. So there are these overlapping constructs to deal with.

The confusion between compassion and empathy probably resulted from my own inconsistency. Eventually compassion was taken out because the focus was on the active processes of empathizing and understanding empathetically. Compassion as a state of being in relation to another’s pain, prior to its activation in empathy, was considered in Chapter 11 in order to explore ways of cultivating compassion that could facilitate empathic ability.

1/14/2004 to 1/15/2004

**Jeff:** The distinction between management facilitators and management is unclear to me, not just conceptually but especially when it comes to categorizing therapist statements into one versus the other domain. Your definition of management facilitators explicitly relies on "the therapist's view" but I don't believe it is ever the case that therapists themselves distinguish between a management factor per se and a management facilitator. In reviewing the core ideas, therapist "awareness" is sometimes categorized as
a facilitator (which I disagree with) and sometimes as a direct management factor, which
seems accurate. I would argue that management facilitators should be external to the
therapist, and anything germane to the therapist (e.g., beliefs, values, knowledge,
awareness) would be management factors.

**Alan:** The criterion I/we used for making the distinction between management and
management facilitator was that a facilitator had to have been part of the therapist’s
practices, traits, attitudes, training, prior resolution of origins, consultatory & other
relationships, etc., BEFORE the therapy relationship in question. In other words, a
facilitator is what you bring to the situation, management is what you do about the
situation. This can cause conceptual confusion and lots of double-coding because when a
therapist consults a trusted colleague, the relationship with the colleague and the
willingness to seek consultation both facilitate the decision to consult, and these factors
can be intermingled in the same sentence from the interview. Our reasoning for making
the distinction along these lines, rather than internal versus external, is that it handles two
questions I’m trying to answer: what can therapists do proactively to facilitate CT
management, and what can they do reactively when faced with CT? I’ll have to look at
the coding for meaning units related to awareness: in some cases I imagine that prior self-
awareness, based on personal therapy or reflection, facilitated rapid identification of
therapist contributions to CT.

**Jeff:** OK, I understand better the distinction b/t management and facilitators; I would
suggest you make the distinction a little clearer in your definitions of domains. For
example, the facilitators def says that the trait should exist before the CT is manifested,
not before the relationship has begun. The def of management says nothing about before
and after.

I failed to follow up on these suggestions in terms of revising the written definitions, but in
further coding adhered to the idea that facilitators had to have existed prior to the therapy
relationship in question.

**Jeff:** In your def of CT, “less than optimal” implies a necessarily negative construct.
Perhaps this is intentional, since you are focused on managing CT, so that which has to
be managed must be negative. Is that consistent with your thinking?

**Alan:** You raise an extremely interesting question here about CT being negative. If one’s
“woundedness,” as one therapist called it, ends up being the avenue through which one
connects deeply with the client and offers a corrective relational experience, then was it
ever negative? The simple answer is that it all depends on what one does with one’s CT,
that it becomes constructive or destructive depending on one’s approach. A deeper
answer that applies to some of the therapists, is that embracing the negative, being with
one’s woundedness rather than trying to control or deny it, allows one to do the same for
the client, which allows the client to do the same for herself or himself. So I’ll check to
see of the semantics of my definition still fit with what the therapists ended up saying
about this issue.
Jeff: Your definition of Origins combines both client and therapist factors. While I agree that CT is ALWAYS a result of interacting client and therapist factors (though to widely varying degrees case to case and instance to instance), I think it is a mistake to allow a client factor, on its own, to be an Origin; your definition of Origins permits this. Doing so allows therapists to disavow their role in CT, which is problematic. You have combined my notions of Origins and Triggers into a single category, which I would suggest you call "Causes," or else separate Origins from Triggers.

Alan: I have in fact changed the domain name from origins to causes (I must have to clean up leftover references to origins) and want to capture the highly interactive nature of client and therapist contributions, but I will try to find a way to make sure that therapist accountability is not in any case taken out of the equation. Certainly none of the therapists treated their reactions as deterministically caused by their clients. Grounded theory allows for constructs that have dimension, e.g. mild to severe pain. Perhaps looking at the different interviews I can place CT on a spectrum from “predominantly therapist-caused” to “predominantly client-caused” and look for any patterns in what path management takes from there. One confounding variable is that therapists may have simply been less explicit or descriptive about one or the other side of it.

Integrating Participant Feedback

When asked for feedback, none of the participating therapists disagreed with the narrative synthesis of the grounded theory, although some amplified their own narratives. Some did report difficulty understanding the narrative synthesis due to its abstract and conceptually dense nature. This was rewritten later to increase clarity and reflect revisions in the overall theory. Several found the flowchart impossible to follow, resulting in major revisions. The most important revision in terms of clarity of presentation was the simplification of the overall flowchart almost down to the level of the major categories. Separate flowcharts were developed to address relationships among subcategories.

Each therapist also received one to two follow-up questions. I had neglected to ask some of the therapists about their personal and professional development following from their reactivity management. These therapists (1, 4, 6, 8, 9, 10 and 11) were asked, and responses were received from Therapists 6 and 10 and were integrated into the Therapist Development category.
The individualized questions and responses follow; the latter were incorporated into the
grounded theory.

(Question for Therapist 2) Is there any way in which your desire to be paternal, or your
work to make sure any paternal behavior was serving the goals of therapy, may have
interfered with the therapy process? In other words, were you always able to be as
therapeutic as you wanted to be?

Therapist 2 Response: I’m never “always able to be as therapeutic as I want to be”!
Suffice it to say that at worst the paternal behavior may have delayed more targeted
work; at best it served a purpose for this client who needed to be in the presence of a
“good parent” figure as she struggled to resolve the circumstances of her loss. She did
come to recognize that my image as parent to her was illusory, though useful in the early
stages.

(Question for Therapist 5) You described your initial reaction to having “dropped the
ball” as shame and guilt, but later as being humbled. How did you make the transition?

Therapist 5 Response: I thought more about the experience of being human, and in a
small way, “forgave” myself.

(Question for Therapist 7) A. Were there further developments in this therapy relationship
that were related to the work you already described in connecting to your client and your
own woundedness?

Therapist 7 Response: This therapist responded verbally that this therapy relationship
continued and was still taxing, but that the shift in the client’s level of safety and level of
engagement was sustained.

(Question for Therapist 10) What were the reactions to your divorce and your former
mother-in-law that you had to overcome in order to feel empathy for her and for your
client? How did you overcome these reactions?

Therapist 10 Response: I had to step back from my own feelings of pain and observe
hers.

This second round of participant involvement ended up being rather minimal. Four of the
therapists never responded to attempts at follow-up contact, and I did not seek to involve them
very deeply in the interpretation process. Ideally I would have conducted an entire follow-up interview with each participant to clarify concepts they used, go over each point in the narrative, and delve more deeply into the experience. The research process would have adhered more closely to Gadamer’s idea (1989) of the circle of interpretations, in which the discovery of truth depends on a communal effort, commitment, and responsiveness.

Applying Evaluation Criteria

Strauss and Corbin (1990, 1998) developed eight criteria for evaluating to what extent a grounded theory is trustworthy. As mentioned in Chapter III, each criterion is a yes/no question, with no means of assessing the degree of compliance. The reader is invited to think critically about areas in which the theory does not seem to be carefully grounded in the data, or where it seems to lack richness and applicability to practice.

1. Are concepts generated?

Strauss and Corbin (1998) suggest that researchers should show how concepts that are borrowed from general use could have evolved directly from the data, as described above in Development of Categories and Integrating Auditor Feedback.

2. Are the concepts systematically related?

   and

3. Are there many conceptual linkages, and are the categories well developed? Do categories have conceptual density?

These criteria can be only be judged by viewing the theory as a whole. In order for the conceptual linkages and density to be grounded, they must not be spurious (have no evidence in the data) and they must be significant (important to fully understand the phenomenon.) Capturing linkages was ensured by scanning the flowchart for any missed connections. A connection could not be made merely because it was supported by logic or personal experience; it had to be represented by at least one therapist account. Density was ascertained by returning to the transcripts multiple times in search of properties that had been missed.
4. Is variation built into the theory?

and

5. Are the conditions under which variation can be found built into the study and explained?

Variation may have been limited by sample size and some homogeneity of therapists’ theoretical orientations and ethnicity. However, family therapy and couple therapy were included, and presenting problems and interpersonal stances varied widely enough to broaden the theory. Variations were explained through reference to specific therapy relationships and underlying differences in interpersonal style, defensive patterns of interaction, and interpersonal needs.

6. Has process been taken into account?

This study is almost entirely focused on process. Content is only important in so far as it makes a difference in the process.

7. Do the theoretical findings seem significant, and to what extent?

Chapters devoted to implications for research, training, and practice identify some of the potential contributions of the findings. They also seem significant in their affirmation of an intersubjective view of therapy, in which both therapists and humans are seen to have relationship needs that form a dynamic that is familiar and unproductive for each.

8. Does the theory stand the test of time and become part of the discussions and ideas exchanged among relevant social and professional groups?

One hopes.

To further assess quality one must identify the individual limitations of the study in comparison to specific methodological recommendations of grounded theory, as discussed in the next section.

Limitations

The limitations of the present study involve participant sampling and lack of theoretical saturation; limited involvement of participants in theory development and revision; uneven
degree of meaning unit analysis; idiosyncratic aspects of investigator bias; and the unique nature of bias toward social acceptability in therapists.

**Participant Sampling and Lack of Saturation**

There is no clear guideline for sample size in grounded theory studies. The sample size may change as further rounds of theoretical sampling are generated by greater clarity in defining the core category. In this study, the core category was to some extent predetermined. If the phenomenon of therapist reactivity had been chosen as a general topic, then any number of core categories could have emerged as contenders, and the first pool of participants recruited would not have had to meet certain criteria, such as perceived success in managing their reactivity. Further stages of sampling were therefore not seen as necessary.

The sample size was chosen to balance the goals of theoretical saturation and manageability. The goal of saturation was also understood to be unattainable in the sense that further expansions and revisions are always possible in the light of new examples. However, saturation is still a relevant dimension in that one can expect a positive relationship between differentiation of theory and sample size up to some indeterminate point, even when taking into account the subjective nature of theoretical saturation.

In retrospect, unique narrative structures like that of therapy dyad 5, differing degrees of therapeutic success and clarity of termination (4, 7, and 11 come to mind), subgroups like dissociative clients with PTSD (3 and 7) and personality disorders (1, 6, 9, 10), and examples of different modalities (family therapy in 4, couple therapy in 12) create questions about differences of approach in reactivity management. These questions might have been tentatively answered through further theoretical sampling.
For example, the extent to which mutual reactivity cycles are present and must be managed and/or used may depend on whether clients (and/or therapists) are adequately disturbed in their interpersonal functioning. While a broad theory of reactivity management has utility and appeal, mini-theories relevant to certain client types as well as certain therapist types may provide an even more useful degree of differentiation, as discussed in Chapter 10.

**Limited Involvement of Participants**

Qualitative research may be more or less collaborative, with participants involved in interpretation and even application of findings. The participants in this study were generous with their time in granting interviews and reviewing initial analyses. Further conversations were prohibitive for both participants and investigator, but would certainly have been valuable in subjecting perceived relationships to scrutiny, elaborating constructs, and integrating individual narratives into a meaningful theory.

**Uneven Degree of Meaning Unit Analysis**

Before the method was shifted to grounded theory and CQR was being followed, the coding team was able to place all meaning units into categories and extract core ideas (succinct phrases identifying the essential meaning) from meaning units in three of the transcripts (1, 2, and 4). The meaning units in the other transcripts were grouped directly into subcategories, although many were summarized as they were grouped. Although in obtaining committee approval for this change I addressed any concerns that could arise about the lack of core ideas for ¾ of the transcripts, it is worth noting here that the loss of multiple perspectives in identifying the essence of each meaning unit may have introduced greater investigator bias. At the same
time, this bias seems much more likely to disrupt the grounding of theory in data at higher levels of abstraction, because relatively little interpretation occurs at the level of core ideas. Most of the debates on how to word core ideas centered on how detailed to be. My personal tendency swayed from rich description that sometimes amounted to a rephrasing of the meaning unit, to brevity that struck other team members as at times losing important information. By the time the team approach was abandoned, I felt myself to have reached a middle ground. Most important in balancing abstraction with detail has been frequent return to the transcripts themselves, searching for differences that make a difference.

Some discussions resulted in reassignment of a meaning unit to a different category or to multiple categories. Occasionally these latter discussions engendered greater theoretical sensitivity in me, but this seems to have carried over into further stages of analysis. An example is the dual nature of reactivity as an impediment to therapy and as an activator of therapist-client dynamics whose examination proves therapeutic. However, there is no way to determine whether a consensual discussion of the remainder of the meaning units might have influenced theory development.

Investigator Biases

Having described my efforts to check my biases above, I make note here of biases I could identify but not overcome. What has become clear over time is that I have biases toward seeing parallel processes, paradoxes, and cycles. These manifested in the idea of valuing contact being internalized by the therapist and offered to the client, in the paradox of empathic acceptance of suffering helping to resolve that suffering, and in the cycle of mutual reactivity.
My attraction to processes that seem structured in these ways is based on a view of psychological wounding and development that is informed by my own personal and professional experience, as well as on an attraction toward nonlinear thinking. A theory that proceeds neatly from A to B to C not only seems to violate the complexity of psychological reality but to hold little interest. Therefore I have required myself to question anything in the theory that appeals to me on aesthetic grounds, by thinking about each therapy relationship and whether I am distorting the data to fit the theory. My auditor has also served this cautionary function, using the metaphor of keeping the Clydesdales of theoretical speculation from getting out of the barn prematurely and running wild. As the person most deeply familiar with the whole of the data, however, the primary responsibility for curbing such theoretical bias has been mine, and is therefore subject to the limitations of my own ability to question myself. Although these processes do seem to emerge from the data, their prominence in the theory may be a function of other processes dropping into the background.

Bias toward Social Acceptability

In assessing their own work, therapists face not only their professional areas of weakness, but also their levels of personal growth. Thus there is an additional motivation for therapists to present themselves well. When asked about their personal reactions, they are being probed in the exact area where mental health and professional acumen intersect. Although they were asked to describe ultimately successful therapy relationships, participants were also asked to describe ways in which their own reactivity threatened this success. Therefore it would be natural for participants to paint a somewhat rosy picture, and to avoid much depth in disclosing their own personal history or psychological wounding.
Given these factors, many participants appeared to be remarkably candid in describing their difficulties and the personal origins of those difficulties. For these therapists, accepting their own humanity seemed to be a core value to them personally and professionally. For reasons of defensiveness or perhaps merely a different boundary regarding privacy, some of the therapists alluded to personal origins in very circumspect ways, or were vague about the degree to which their reactivity may have influenced the therapy relationship. Ultimately there is no perspective available that could resolve such questions; only development of a more trusting interviewer-interviewee relationship would yield more information.

My assessment following the interview process was that certain therapists were more difficult to interpret than others; this response was shared by team members during category development and assignment of meaning units to categories. During interviewing there was a tendency on my part to accept vague constructs and gloss over apparent logical gaps, because in an effort to create a safe environment for self-disclosure one tends to be less challenging. Another factor seems to be that the effort to enter into the interviewee’s mindset leads one to understand on an intuitive level without noticing that one lacks precision about certain meanings. Follow-up questions (above) were useful in clarifying some of these meanings, but some difficulties of interpretation seemed to result from interviewee defensiveness or lack of conceptual clarity.

Reflections on Grounded Theory as a Developmental Experience

One common ground between the practice of psychotherapy and the practice of grounded theory is the use of self as instrument. In the process of interviewing experienced psychotherapists, searching through their words, generating theory, critically examining my
inferences, and reflecting on the implications for my own practice, I became aware of my responsibility to my readers and my own values. This responsibility feels similar to my commitment to my clients’ development. At the same time, I felt inspired by the commitment shown by the twelve therapists I had the fortune to meet. Burden and inspiration were balanced by a deeper appreciation for limits. Perhaps my own greatest source of reactivity is my attachment to fulfilling ideals. On a daily basis both my clinical work and my research work have confronted me with the limits that the body, heart, and mind impose. One cannot do it all, but one can do what is needed.

Thus my own experience has paralleled that of some of the therapists, who in accepting their own humanity made a safe place for their clients to do so. And this experience, I believe, has extended to my own clients, as I have become more comfortable using, and being, myself. The twelve therapists who offered their time, wisdom, and humanity accompanied me in spirit as I entered private practice, telling me that if they could bring their whole selves into their work, and not just be experts anxiously defending their identities, then so could I.

More specifically, my interactions with certain therapists led me down unanticipated paths of development. As I worked through the final stages of data analysis I was invited to participate in the same gestalt training to which several participants had referred. My appreciation for the realities of interpersonal contact, psychological woundedness, and healing was deepened both conceptually and experientially. I also followed up on learning about tonglen, and though I have only practiced it briefly and sporadically, the tape series by Pema Chödrön gave me a rich feeling for the possibilities inherent in this practice of compassion toward self and others.
Finally, the enormity of the task presented by grounded theory has taught me that I can make a sustained intellectual effort on a scale I could never have imagined (and worked carefully not to imagine while in the middle of it!), with the support of family, friends, and mentors. One never really does anything alone. Perhaps this is the most basic lesson to be learned from the whole process and all of the people involved: becoming always occurs in the intersubjective field. One discovers one’s unique truth in relationship to and with the encouragement of other people, even as one helps them discover theirs.
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The Pennsylvania State University

Title of project: Management and Use of Personal Reactions to Clients

Person in charge: Alan Baehr
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State College, PA 16801
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1. This section provides an explanation of the study in which you will be participating:

The study in which you will be participating is intended to contribute to the field of psychology a better understanding of how experienced therapists manage and use their personal reactions to clients for the benefit of those clients.

If you agree to participate in this research, you will be asked to discuss with the principle investigator an experience with a client of your choosing whom you found challenging, at least in part because of your personal reactions. The interview will be audiotaped. The transcript of your interview, together with about a dozen others, will be used to draw conclusions about the process of effective management and use of personal reactions in therapy.

After the interview is transcribed, the interviewer will contact you by telephone to ask follow-up questions, and to invite you to schedule another face-to-face interview if you wish to contribute further, following the same procedures. You will also have the opportunity to contribute to the narrative account describing your experience, and the model developed to describe the process common to all participants.

Your participation in this research will take a minimum of ninety (90) minutes, including reading and completing the enclosed forms (15 minutes), reflection on interview questions prior to the interview (15 to 30 minutes), the interview itself (45 to 60 minutes), and the follow-up telephone interview (15 to 30 minutes).

In participating in this research, you may experience some emotional discomfort such as embarrassment in discussing your personal reactions to clients.

The only people with access to audio recordings of your participation will be those who transcribe the interviews and the principle investigator. The research team members (Chad Johnson and Randy Patterson), and the research supervisor (Jeff Hayes) will have access to the transcripts only, which will not reveal the identity of the participants. Transcripts of interviews will be included in an appendix to the dissertation with your written consent only, which may be withdrawn at any time prior to printing (of which you will be notified two weeks in advance). Full transcripts will not be included in any publication derived from the dissertation; however, excerpts may be included. Once the study is completed, all recordings other than transcripts will be destroyed by the principle investigator. Transcripts will be kept confidential and any further research based on them will be conducted only with your informed consent. You will receive a copy of your own transcript. If you decide to withdraw from this study at any time, any recordings of your participation including transcripts will be destroyed as soon as possible, unless you request them for yourself. When recordings are destroyed, you will receive written notification.
2. This section describes your rights as a research participant:

You may ask any questions about the research procedures, and these questions will be answered. Further questions should be directed to Alan Baehr.

Your participation in this research is confidential. Only the principle investigator will have access to your identity or information that could be associated with your identity. Transcribers will be selected who are not familiar with therapists within a two-hour drive of State College.

Your participation in this research is voluntary. You are free to stop participating in the research at any time, or to decline to answer any specific questions without penalty.

This study involves minimal risk; that is, no risks to your physical or mental health beyond those encountered in the normal course of everyday life.

3. This section indicates that you are giving your informed consent to participate in the research:

Participant:

I agree to participate in an investigation of therapists’ management of personal reactions to clients, as an authorized part of the education and research program of the Pennsylvania State University.

I understand the information given to me, and I have received answers to any questions I may have had about the research procedures. I understand and agree to the conditions of this study as described.

To the best of my knowledge and belief, I have no physical or mental illness or difficulties that would increase the risk to me of my participation in this study.

I understand that I will receive no compensation for participating.

I understand that my participation in this research is voluntary, and that I may withdraw from this study at any time by notifying Alan Baehr.

I am 18 years of age or older.

I understand that I will receive a signed copy of this consent form.

________________________________ ____________
Signature     Date

Researcher:

I certify that the informed consent procedure has been followed, and that I have answered any questions from the participant above as fully as possible.

________________________________ ____________
Principal Investigator’s Signature  Date
Demographic Form

Research on Management and Use of Personal Reactions to Clients

☐ Not interested in participating (please write name below)

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APPENDIX B: SEMI-STRUCTURED INTERVIEW PROTOCOL

In preparation for the interview, choose a client of yours who meets the following criteria:

A. Completed therapy within the past 12 months (the more recent the better).

B. Evoked in you personal reactions (e.g., emotions, thoughts, or behaviors) that made therapy challenging.

C. Ultimately made some therapeutic gains, from your point of view at least in part as a result of your efforts in dealing with whatever the client evoked in you.

The following questions will be asked in the course of the interview. Please allow yourself time to think about these questions before the interview. You may wish to put your thoughts in writing if you find this helpful.

1. How would you describe this client (demographic information, presenting complaints, family background, case conceptualization)? Please omit (rather than change) any information that could reveal the identity of the client.

2. How would you describe your relationship with this client (e.g., in terms of emotional climate, roles, working alliance, relationship patterns)? How did the relationship change over the course of therapy?

3. What personal reactions (e.g., emotions, thoughts, or behaviors) did the client evoke in you that made therapy challenging?

4. How were these reactions evoked by the client (e.g., client traits, behaviors, material discussed)?

5. How and when did you become aware of your reactions? What steps if any had you taken to develop this awareness of personal reactions (either in relation to this client, or more generally)?

6. If you tried to understand and/or change your reactions, how and when did you do so (i.e., in sessions, between sessions)?

7. What effects did your attempts to understand and/or change your reactions seem to have on the client and the therapy relationship? On therapy outcome?

8. What qualities in you helped you to successfully manage your personal reactions?

9. If there is anything you would do differently now, what would it be?

10. What is your overall attitude toward having personal reactions to clients?

11. In what ways if any did you grow personally as a result of dealing with your reactions to this client?
APPENDIX C: THE PRACTICE OF TONGLEN
by Pema Chödrön from When Things Fall Apart:Heart Advice for Difficult Times

citation:  http://www.acupuncturedoc.com/tonglen.htm

Each of us has a "soft spot": the place in our experience where we feel vulnerable and tender. This soft spot is inherent in appreciation and love, and it is equally inherent in pain.

Often, when we feel that soft spot, it's quickly followed by a feeling of fear and an involuntary, habitual tendency to close down. This is the tendency of all living things: to avoid pain and cling to pleasure. In practice, however, covering up the soft spot means shutting down against out life experience. Then we tend to narrow down into a solid feeling of self against other.

One very powerful and effective way to work with tendency to push away pain and hold onto pleasure is the practice of tonglen. Tonglen is a Tibetan word that literally means "sending and taking." The practice originated in India and came to Tibet in the eleventh century. In tonglen practice, when we see or feel suffering, we breathe in with the notion of completely feeling it, accepting it, and owning it. Then we breathe out, radiating compassion, lovingkindness, freshness; anything that encourages relaxation and openness.

In this practice, it's not uncommon to find yourself blocked, because you come face to face with your own fear, resistance, or whatever your personal stuckness happens to be at that moment. At that point, you can change the focus and do tonglen for yourself, and for millions of others just like you, at that very moment, who are feeling exactly the same misery.

I particularly like to encourage tonglen, on the spot. For example, you're walking down the street and you see the pain of another human being. On-the-spot tonglen means that you just don't rush by; you actually breathe in with the wish that this person can be free of suffering, and send them out some kind of good heart or well-being. If seeing that other person's pain brings up fear or anger or confusion, which often happens, just start doing tonglen for yourself and all the other people who are stuck in the very same way.

When you do tonglen on the spot, you simply breathe in and breathe out, taking in pain and sending out spaciousness and relief. When you do tonglen as a formal practice, it has four stages:

1) First, rest your mind briefly in a state of openness or stillness.

2) Second, work with texture. Breathe in a feeling of hot, dark, and heavy, and breathe out a feeling of cool, bright, and light. Breathe in and radiate completely, through all the pores of your body, until it feels synchronized with your in-and out-breathe.

3) Third, work with any painful personal situation that is real to you. Traditionally, you begin by doing tonglen for someone you care about. However, if your stuck, do the practice for your pain and simultaneously for all those just like you who feel that kind of suffering.
4) Finally, make the taking in and the sending out larger. Whether your doing tonglen for someone you love or for someone you see on television, do it for all the others in the same boat. You could even do tonglen for people you consider your enemies—those who have hurt you or others. Do tonglen for them, thinking of them as having the same confusion and stickness as your find or yourself.

This is to say that tonglen can extend indefinitely. As you do the practice, gradually, over time, your compassion naturally expands-- and so does your realization that things are not as solid as you thought. As you do this practice, at your own pace, you'll be surprised to find yourself more and more able to be there for others, even in what seemed like impossible situations.

**Transforming Confusion into Wisdom**

*City Retreat | Berkeley Shambhala Center*  
*Fall 1999*

Citation: [http://www.shambhala.org/teachers/pema/tonglen1.php](http://www.shambhala.org/teachers/pema/tonglen1.php)

The Practice of Tonglen

In order to have compassion for others, we have to have compassion for ourselves.

In particular, to care about other people who are fearful, angry, jealous, overpowered by addictions of all kinds, arrogant, proud, miserly, selfish, mean —you name it— to have compassion and to care for these people, means not to run from the pain of finding these things in ourselves. In fact, one's whole attitude toward pain can change. Instead of fending it off and hiding from it, one could open one's heart and allow oneself to feel that pain, feel it as something that will soften and purify us and make us far more loving and kind.

The tonglen practice is a method for connecting with suffering —ours and that which is all around us— everywhere we go. It is a method for overcoming fear of suffering and for dissolving the tightness of our heart. Primarily it is a method for awakening the compassion that is inherent in all of us, no matter how cruel or cold we might seem to be.

We begin the practice by taking on the suffering of a person we know to be hurting and who we wish to help. For instance, if you know of a child who is being hurt, you breathe in the wish to take away all the pain and fear of that child. Then, as you breathe out, you send the child happiness, joy or whatever would relieve their pain. This is the core of the practice: breathing in other's pain so they can be well and have more space to relax and open, and breathing out, sending them relaxation or whatever you feel would bring them relief and happiness. However, we often cannot do this practice because we come face to face with our own fear, our own resistance, anger, or whatever our personal pain, our personal stickness happens to be at that moment.

At that point you can change the focus and begin to do tonglen for what you are feeling and for millions of others just like you who at that very moment of time are feeling exactly the same
stuckness and misery. Maybe you are able to name your pain. You recognize it clearly as terror or revulsion or anger or wanting to get revenge. So you breathe in for all the people who are caught with that same emotion and you send out relief or whatever opens up the space for yourself and all those countless others. Maybe you can't name what you're feeling. But you can feel it—a tightness in the stomach, a heavy darkness or whatever. Just contact what you are feeling and breathe in, take it in—for all of us and send out relief to all of us.

People often say that this practice goes against the grain of how we usually hold ourselves together. Truthfully, this practice does go against the grain of wanting things on our own terms, of wanting it to work out for ourselves no matter what happens to the others. The practice dissolves the armor of self-protection we've tried so hard to create around ourselves. In Buddhist language one would say that it dissolves the fixation and clinging of ego.

Tonglen reverses the usual logic of avoiding suffering and seeking pleasure and, in the process, we become liberated from a very ancient prison of selfishness. We begin to feel love both for ourselves and others and also we being to take care of ourselves and others. It awakens our compassion and it also introduces us to a far larger view of reality. It introduces us to the unlimited spaciousness that Buddhists call shunyata. By doing the practice, we begin to connect with the open dimension of our being. At first we experience this as things not being such a big deal or so solid as they seemed before.

Tonglen can be done for those who are ill, those who are dying or have just died, or for those that are in pain of any kind. It can be done either as a formal meditation practice or right on the spot at any time. For example, if you are out walking and you see someone in pain—right on the spot you can begin to breathe in their pain and send some out some relief. Or, more likely, you might see someone in pain and look away because it brings up your fear or anger; it brings up your resistance and confusion.

So on the spot you can do tonglen for all the people who are just like you, for everyone who wishes to be compassionate but instead is afraid, for everyone who wishes to be brave but instead is a coward.

Rather than beating yourself up, use your own stuckness as a stepping stone to understanding what people are up against all over the world.

Breathe in for all of us and breathe out for all of us.

Use what seems like poison as medicine. Use your personal suffering as the path to compassion for all beings.
TONGLEN INSTRUCTIONS

When you do tonglen on the spot, simply breathe in and breathe out, taking in pain and sending out spaciousness and relief.

When you do tonglen as a formal meditation practice it has four stages. First rest your mind briefly, for a second or two, in a state of openness or stillness. This stage is traditionally called "flashing on Absolute bodhicitta" or suddenly opening to basic spaciousness and clarity.

Second, work with texture. You breathe in a feeling of hot, dark and heavy—a sense of claustrophobia, and you breathe out a feeling of cool, bright and light—a sense of freshness. You breathe in completely through all the pores of your body and you breathe out, radiate out, completely through all the pores of your body. You do this until it feels synchronized with your in and outbreath.

Third, you work with your personal situation—any painful situation which is real to you. Traditionally you begin by doing tonglen for someone you care about and wish to help. However, as I described, if you are stuck, do the practice for the pain you are feeling and simultaneously for all those just like you who feel that kind of suffering. For instance if you are feeling inadequate—you breathe that in for yourself and all the others in the same boat—and you send out confidence or relief in any form you wish.

Finally make the taking in and ending out larger. If you are doing tonglen for someone you love, extend it out to everyone who is in the same situation. If you are doing tonglen for someone you see on television or on the street, do it for all the others who are in the same boat—make it larger than just one person. If you are doing tonglen for all those who are feeling the anger or fear that you are caught with, maybe that is big enough.

But you could go further in all these cases. You could do tonglen for people you consider to be your enemies—those that hurt you or hurt others. Do tonglen for them, thinking of them as having the same confusion and stuckness as your friend or yourself. Breathe in their pain and send them relief.

This is to say that tonglen can extend indefinitely.

As you do the practice, gradually over time, your compassion naturally expands and so does your realization that things are not as solid as you thought. As you do this practice, gradually at your own pace, you will be surprised to find yourself more and more able to be there for others even in what used to seem like impossible situations.
VITA

Alan Baehr

EDUCATION

Bachelor of Arts in English, May 1987. University of New Mexico.

HONORS

- Graduate Fellow at Pennsylvania State University
- Merit Scholarship, UC Berkeley
- Phi Beta Kappa
- Summa Cum Laude in General Honors
- Presidential Scholarship, University of New Mexico
- High School Valedictorian

CLINICAL EXPERIENCE

- Provide individual, couple, and group psychotherapy to adults with a range of disorders at an interdisciplinary practice.

- Supervised support staff, referred new clients to appropriate clinicians, developed and implemented clinical policies.

- Provided intake assessments, psychological testing, crisis intervention, and individual, couple, and group psychotherapy to students.

- Provided intake assessments, career counseling, and time-limited individual psychotherapy to undergraduate and graduate students.

- Provided intake assessments, career counseling, and time-limited individual psychotherapy to undergraduate and graduate students.

- Provided psychotherapy to children and adolescents and their families at risk of out of home placement.

- Provided supportive group psychotherapy and psychoeducation to adults with serious and persistent mental illness.

- Provided individual and group counseling to adults and adolescents with alcohol and/or substance abuse disorders.

- Provided crisis intervention, individual, and group psychotherapy to veterans and their partners.

- Provided intensive case management, individual and group therapy to adults with serious and persistent mental illness.

Mental Health Assistant: Walnut Creek Psychiatric Hospital, Walnut Creek, CA. June 1992 to May 1993.
- Assessed mental status, maintained therapeutic milieu, and provided brief individual counseling in child and adult inpatient units.

- Facilitated social, vocational and recreational activities for adults with serious and persistent mental illness and/or mental retardation.

Mental Health Assistant: The Arbour Psychiatric Hospital, Jamaica Plain, MA. April 1989 to February 1990.
- Assessed mental status, maintained therapeutic milieu, provided brief counseling and conducted community meetings.