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Wounded Healers in Practice: A Phenomenological Study of Jungian Analysts' Countertransference Experiences

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Abstract

This study explored Jungian analysts' experiences of countertransference (CT) using the qualitative method interpretive phenomenological analysis (IPA). The purpose of this study was to better understand how Jungian analysts experience, understand, make use of, and manage CT in daily practice. Six certified Jungian analysts were interviewed about their CT experiences from their analytic work with a past client. The study's main findings were that CT originated primarily from analysts' personal wounds and tended to manifest as analysts' disengagement or withdrawal from the client. Furthermore, analysts often used awareness and understanding of their CT to better manage CT. The nature of the therapeutic relationship was often influenced by CT and also emerged as an important factor in analytic process and outcome. Finally, this study found that contextual factors such as time, culture, and spiritual elements were key influences in the transference-countertransference dynamic. Overall, this study represents a step towards developing an empirical understanding of CT in Jungian models and hopefully facilitates a long-overdue dialogue between Jungians and mainstream practitioners, particularly those adhering to relational or interpersonal approaches.

Keywords: countertransference, Jungian analysis, relational, wounded healer

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> The intelligent psychotherapist has known for years that any complicated treatment is an individual, *dialectical* process, in which the doctor, as a person, participates just as much as the patient….We could say, without too much exaggeration, that a good half of every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself can he hope to put right in the patient. It is no loss, either, if he feels that the patient is hitting him, or even scoring off him: it is his own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the Greek myth of the wounded physician. (p. 116)

These words, written by Carl Jung (1951/1966) over sixty years ago, seem startlingly relevant to contemporary psychodynamic thought. During Jung's time, the idea of psychotherapy as a two-way interaction in which the patient *and therapist* are both deeply emotionally involved in and affected by the therapeutic situation was quite radical (Samuels, 1985b, 2008). Today, however, many relational and intersubjective psychoanalytic models embrace the notion of mutual influence and acknowledge the unavoidable involvement of the analyst's subjectivity in the therapeutic process (Mitchell, 2000; Safran, 2012; Safran & Muran, 2002).

Jung and Countertransference

Jung emphasized the critical healing value of unconscious intermingling between patient and therapist, a phenomenon otherwise known as the transference-countertransference dynamic (Perry, 2008; Samuels, 2006). More specifically, Jung (1931/1966) was prescient in recognizing the potential clinical utility of CT, describing it as a "highly important organ of information" (p. 71) to be used by therapists. Although this viewpoint contradicted the Freudian convention at the

time, which considered CT an obstacle to treatment, the therapeutic significance of managing CT is now supported by research and widely accepted in the psychotherapy literature (Gelso & Hayes, 2002, 2007; Hayes, Gelso, & Hummel, 2011).

Related to CT management, Jung stressed the importance of the therapist using himself when working with patients, rather than relying on a specific technique, per se (Sedgwick, 1994, 2001; Wiener, 2004, 2009, 2010). Jung stated, "Every psychotherapist not only has his own method—he himself is that method…the great healing factor in psychotherapy is the doctor's personality" (Jung, 1945/1966, p. 88). This statement means, at least in part, that every therapist unavoidably brings his or her whole unique self into session and that it's the therapist's openness and genuine emotional engagement with the patient that really cures (Sedgwick, 1994, 2001). Put another way, as the unconscious bond deepens over time, therapists may best serve their patients by effectively dealing with their own countertransferential stuff that gets constellated by patient material (Sedgwick, 1994). This idea fits with current strains of relational thought acknowledging that the raw materials (past experiences, personality traits, behavioral patterns) that *both* parties bring to the room may significantly affect the course of treatment in each unique, interpersonal context (Wachtel, 2008).

Jungians and Countertransference

A number of so-called post-Jungians have developed ideas about CT over the years, many of which complement contributions to CT theory made by notable psychoanalysts such as Robert Langs, Margaret Little, Paula Heimann, Heinrich Racker, and Harold Searles (for reviews see Machtiger, 1995; Perry, 2008; Samuels, 2006; Sedgwick, 1994; Wiener, 2009). Furthermore, many contemporary Jungians, particularly those influenced by developmental and psychodynamic theory, increasingly focus on the transference-countertransference field as the

primary site of therapeutic action in their clinical work (Samuels, 2008; Sedgwick, 2001; Solomon, 2008).

Research. Despite the fact that Jungians as a whole have been thinking and writing about CT for the past half-century, there is a paucity of research on what CT actually looks like in Jungian practice. To date, there appears to be only two empirical studies of the phenomena of CT in Jungian analysis. The first, conducted in Germany by Hans Dieckmann (1974, 1976), established a chain of associations between the analyst's unconscious reactions and that of the patient's. The second, conducted by leading Jungian thinker Andrew Samuels (1985a), demonstrated the emergence of an imaginal third area shared by the unconsciouses of patient and analyst. Additionally, the Jungian and analytical psychology literature contains a modicum of case vignettes, usually presented as a way of illustrating a particular theoretical point or demonstrating the utility of a particular technique (Astor, 2007; Colman, 2010; Jacoby, 2000; Machtiger, 1984; Proner, 2002; Schaverien, 2007; Steinberg, 1990). The aforementioned set of research, however, suffers from a general lack of rigor that casts significant doubt on the validity of the findings (for more detail, see Literature Review).

David Sedgwick (1994) wrote a book-length analysis of CT from a Jungian perspective. In it, he provides a variety of clinical case illustrations detailing transference-countertransference dynamics from his personal experience. Noting the near absence of research examining CT in Jungian practice despite a rich body of theoretical literature, Sedgwick (1994) proposed that Jungians are essentially ignoring an entire area of study:

> Countertransference discussions generally show the finished products rather than the ways and means of working with countertransference. The actual phenomenology of the countertransference—what the experience is really "like," what is happening "in" the

> analyst and how it evolves—receives less attention. Yet Jung and his recent followers stress the importance of this dimension of Jungian clinical practice and directly or implicitly call for some real explication of it. (p. 38)

Verena Kast (2010), an internationally known Jungian, has recently echoed this call. She requested that more experiential research be done—the "kind of research that emerges out of experiences in the consulting room" (p. 349).

One study, Catlin (2006), examined what it's really like in contemporary Jungian analysis using a relatively rigorous qualitative methodology. Catlin's project considered a number of therapeutic process factors such as how Jungian analysts establish an analytic relationship in the early phase of treatment and what analysts identify as essential components of Jungian analysis. Catlin's study found that most Jungian analysts considered attending to the analytic relationship to be a critical component of analysis, emphasizing its dialectical nature and the integral involvement of the person of the analyst. It was also found that the majority of participants stressed the need for analysts to undergo their own personal analysis in order to be more effective clinicians. Catlin concluded that analysts developed sufficient self-awareness through their own therapy to facilitate management of difficult personal reactions and prevent their own psychological material from interfering with treatment of the client—in other words, they learned to successfully harness or manage their CT in service of the work.

The current study will expand upon Catlin's research by exploring in more depth how the Jungian analyst affects and is affected by the analytic process, focusing on how analysts deal with challenging CT reactions evoked by specific clients. Further, in an effort to increase the likelihood of analysts being able to report meaningful CT experiences, this study will investigate courses of longer-term Jungian analysis, where deeper unconscious processes are presumably at

play. In doing so, this study represents a step forward—beyond the constraints of Catlin's study, which restricted its focus to the first year of analysis.

Non-Jungian Contributions

Beyond Jungian psychology, a modest amount of CT research exists, although qualitative investigations lag behind, with attendant calls for researchers to conduct more clinically-relevant qualitative studies into therapists' subjective experiences or management of CT—focusing on therapists' emotions, perceptions, and psychological makeup (Fauth, 2006; Gelso & Hayes, 2007; Rosenberger & Hayes, 2002b). The legitimacy of this research direction is supported by the growing recognition of intersubjective dynamics in the therapeutic relationship, as well as empirical studies highlighting the role of therapist needs and unresolved conflicts in the manifestation and management of CT (Hayes et al., 2011).

Over the past few years, a handful of qualitative dissertations that systematically examined therapists' experiences of CT have been conducted, suggesting a possible trend in this area (e.g., Baehr, 2005; Cooper-White, 2001; Davidtz, 2007; Ham, 2009; Kholocci, 2008; Pitre, 2008; Weisshaar, 2008). Participants in these studies tended to be experienced therapists representing a wide range of theoretical orientations and practices (e.g., addictions counseling, pastoral counseling, and social work). Although this small body of research lacks theoretical and methodological coherence, it generally supports the idea that therapists' phenomenological world matters, and that their subjective and emotional experiences, perceptions, self-awareness, and self-care (the latter two often developed through personal therapy) tend to be important factors in their ability to successfully manage CT. The present study's focus on therapists' phenomenological experiences of CT, with specific attention to the therapist's personality, fits with these broader developments in psychotherapy research.

Baehr's (2005) grounded-theory study of CT management in experienced psychotherapists stands out as particularly relevant. A major implication of Baehr's study is that therapists who have suffered psychological wounds, and have become aware of and worked on these wounds, may have greater capacity to help clients in part because of their ability to manage emotional reactivity. Like Jung, Baehr used the metaphor of the wounded-healer to describe this phenomenon. As Baehr pointed out, an important implication of wounded-healing is that the therapist's wounds can also potentially damage the therapeutic relationship or harm the client or therapist.

The present study employed the wounded-healer motif to explore CT and extended Baehr's study by exploring how this idea may manifest in the context of Jungian analysis. However, unlike Baehr, who restricted therapists to discussing only instances of successful management of CT, this study was open to times when therapists' subjectivity may have impinged upon the analytic process and perhaps even hurt the client in some way.

Rationale for Present Study

Jungians and non-Jungians alike may profit from examining what is going on in Jungian psychotherapy, particularly in the area of CT. Although the phenomenon of CT is complex, with no single, agreed-upon definition, most would agree that its manifestation is ubiquitous and its management often challenging but important for getting through difficult periods in therapy (Gelso & Hayes, 2007; Hayes et al., 2011). As summarized by Sedgwick (1994), "countertransference-based work is in some ways a psychotherapy of impasse, of the analyst's getting stuck, 'hooked' or fused with the patient's infectious, constellating unconscious…and thus almost all countertransferences are manifestly or potentially difficult" (p. 137). As a whole, then, the highly diverse group referred to as Jungians may be enriched and challenged by

exploring, discussing, and critiquing how other Jungians deal with their subjective reactions in session.

For others, such as psychodynamically-oriented therapists, analytical psychology offers many unique ideas such as the archetypes (e.g., Merchant, 2012; Stevens, 2006), the individuation process (e.g., Schmidt, 2005; Stein, 2005, 2006a), the experience of the numinous (e.g., Corbett, 2006; Heuer, 2010; Stein, 2006b; Tacey, 2006), and the notion of a transpersonal dimension of the psyche (e.g., Ulanov, 1995, 2008). These concepts form the skeleton of basic Jungian theory and are inseparable from Jungians' considerations of unconscious dynamics in psychotherapy (Humbert, 1988; Salman, 2008). Learning more about the application of these concepts to CT in Jungian work may enrich the thinking of researchers and practitioners from other therapeutic traditions (Kast, 2010). Being open to what Jungian psychology has to say may allow for a more informed, productive, critical, and perhaps creative interchange between those who have been influenced by Jung (either significantly or slightly) and those who have not (Beebe, Cambray, & Kirsch, 2001).

There are signs that the time is right for taking steps to promote a more fertile discourse (Jacoby, 2000). For instance, a degree of rapport has already developed in more recent years between Jungian and psychodynamic communities as evidenced by Jungians studying common areas such as the development and maintenance of the therapeutic relationship (e.g., Knox, 2010; Sedgwick, 2001; Wiener, 2009), unconscious dynamics and intersubjectivity (e.g., Carter, 2010; Cwik, 2010), psychology and neuroscience (e.g., Goodwyn, 2010, 2012; Knox, 2004; Wilkinson, 2010), and constructivist epistemologies in clinical theory, research, and training (e.g., Hauke, 2000; Horne, 2007; Young-Eisendrath, 1991, 2000, 2004). Further, Joseph Cambray (2002,

2010), a leading post-Jungian thinker, surveyed a group of psychoanalysts about areas of interest and found that "the single most important area identified by the majority of respondents is an in-depth exploration of shared clinical experience…" (p. 76). He also concluded that the "clinical significance of the numinous offers opportunities for dialogue," (p. 76), a finding consistent with the growing interest in spirituality and psychotherapy (e.g., Clark, 2012; Corbett & Stein, 2005; Main, 2003; Tacey, 2004; Stein, 2004) and indicative of a budding openness to Jungian thought.

The Current Project

The present study addresses the aforementioned research gap in regards to CT in Jungian analysis. More specifically, this study was designed to probe how Jungian analysts experience and work with positive or negative feelings, thoughts, fantasies, images, bodily sensations, etc. that seem to be, at least in part, a subjective reaction to unconscious communications from the patient. Taking a closer look at what it is like for Jungian analysts to manage challenging CT reactions will hopefully provide some practical insights into how to survive difficult phases of treatment. If so, the current study would meaningfully contribute to the growing literature on resolving difficulties, impasses, and therapeutic alliance ruptures (see Eubanks-Carter, Muran, & Safran, 2010; Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011), perhaps opening space for productive cross-fertilization between Jungian and psychodynamic models.

The current study addresses the following research questions:

1. What do analysts' experiences of CT *look like*, or how do CT phenomena manifest themselves, in Jungian analysis?
2. How do Jungian analysts make sense of or understand their CT reactions?
3. How do Jungian analysts manage their CT experiences?
4. How does the analyst's subjectivity or personality *affect* the analytic process?
5. How is the analyst's subjectivity or personality *affected by* the analytic process?

Literature Review

In this chapter, I define CT for the purposes of the current study. Next, I briefly describe some unique contributions of Jungian psychology as they relate to CT. The rest of the chapter is divided into two main sections, Jungian CT theory and CT research. The former discusses two major themes (i.e., the analyst's personality and dangers of CT work) that emerged from my review of the Jungian literature. The latter details the only two empirical CT studies (Dieckmann, 1974, 1976; Samuels, 1985a) found in the Jungian literature as well as one related study on Jungian analytic process (Catlin, 2006). This chapter also highlights the main findings that have emerged from the mainstream CT empirical literature, with special emphasis on Baehr's (2005) qualitative study of CT management.

Defining the Phenomenon of Countertransference

In the current study, CT is defined as analysts' sensory, affective, cognitive, and behavioral reactions to clients that are based largely on the analyst's own personality and psychology —particularly his or her unresolved conflicts, pathology or wounds, unmet needs, biases, or complexes. The definition of CT assumes that most of the reactions originate in the unconscious interaction between client and analyst. However, some degree of conscious awareness must develop, at some point, in order for the analyst to be able to effectively *use* CT in session (or to discuss it in a semi-structured interview).

The definition of CT builds on themes from within both the Jungian and mainstream psychotherapy literatures and is consistent with a cornerstone of Jung's theories of psychotherapy—"that the analysts' personality is *the* 'main factor in the cure'" (Sedgwick, 1994, p. 12). More specifically, the definition emphasizes the role of analysts' unresolved conflicts and difficulties, which is consistent with Jung's notion of the wounded healer, or the idea that the

analysts' own suffering is instrumental in the healing process (Samuels, 2006; Sedgwick, 1994, 2001—for details, see *analyst-as-wounded-healer* below). Furthermore, the emphasis on the unconscious origins of CT reflects a central premise of Jungian analysis: that the deepening of the interaction between client and analyst unconsciouses—"the heart of the countertransference-transference" (Sedgwick, 1994, p. 13)—is essential for facilitating meaningful change.

The definition of CT was also influenced by contemporary mainstream CT literature, especially Gelso and Hayes's (2007) integrative conception of CT. Integrative definitions of CT are favored for their moderate standpoint, a quality that minimizes potential investigative pitfalls of defining the phenomenon in overly narrow (i.e., classical view) or broad (i.e., totalistic view) terms (for detailed discussion see Hayes et al., 2011). In addition, integrative definitions reflect contemporary CT research findings by emphasizing the role of the analyst's subjectivity. In fact, Hayes (2002) has argued that the wounded healer motif is a legitimate lens from which to consider therapists' use of self in psychotherapy, highlighting the necessity of therapists tending to their own problems or wounds in order to make beneficial use of CT. As Gelso and Hayes (2007) described:

> The therapist's wounds need to be sufficiently healed to be drawn from usefully. We would argue that one's vulnerabilities and conflicts are never fully resolved, nor do they need to be. In fact, a therapist's issues probably need to be alive enough so that they are available to be drawn upon in the work. Conflicts that are dormant or sealed off cannot be used to relate to the patient. The ideal, then, would be for therapists to be more healed than wounded, to be able to empathize with patients' woundedness and to offer patients a lived sense of potential healing. (pp. 110-111)

Unique Contributions of Jungian Psychology

Jungian psychology has a number of unique ideas and concepts that may deepen our understanding of the transference-countertransference dynamic. The key, distinctive element of Jungian thought is its consideration of the archetypal dimension of the unconscious and, hence, archetypal aspects of the transference (Salman, 2008; Stein, 2006b).

Individuation. The process of individuation is the primary leitmotif running throughout Jung's work. On one level, it is the process by which a person differentiates from others by developing his unique personality while at the same time adapting to world demands. On another level, it is how an individual, in essence, develops a good working relationship with the unconscious (Samuels, 1985b). The experience of individuation often involves enhanced self-awareness and authenticity, and a transcendent sense of purpose—of becoming who one is meant to be. Jung stressed that individuation does not necessarily require analysis in order to unfold, but for some, analysis can play an important role (Stein, 2006a). For example, analysts may gain insight into their clients' individuation (and maybe their own) by attending to what is happening in the transference-countertransference, where the Self (see below) attempts to guide and communicate.

The Jungian unconscious. Jung's main thesis was that the unconscious is inherently purposive, creative, and naturally self-healing. It generates meaningful material (expressed in dreams, CT feelings and images, synchronistic experiences, etc.) that can potentially guide a person towards individuation (Salman, 2008; Samuels, 1985b). The following is a brief description of important parts of the Jungian unconscious, considered in relation to CT, analysis, and individuation.

The archetypes. It is well known that Jung separated the unconscious into personal and transpersonal layers (Hauke, 2006). The deepest layer, called the collective unconscious, houses the archetypes, which Jung described as universal structures or predispositions for understanding one's experience. Archetypes are not specific images or ideas that are somehow innately acquired (Samuels, 1985b); rather, they are inherited *potentialities* of images or ideas, the particular form or expression of which is influenced by individual experiences (Sharp, 1991). Archetypes are also characterized by their bipolarity (e.g., the oft-cited great mother/terrible mother dichotomy) and their ability to exert influence on transference dynamics (e.g., the client idealizes the analyst by projecting the healer archetype onto the analyst; Samuels, 1985b; Stevens, 2006).

Self. The Self is the central archetype, a transcendent power that guides an individual towards individuation (Colman, 2006). In analysis, the Self may essentially act through the transference by stimulating certain thoughts, feelings and images that are important to the individuation process (Samuels, Shorter, & Plaut, 1986).

Complex. A complex is a grouping of ideas and images that share a common affective tone (Samuels, 1985b). Each complex has a personal component, usually originating from past experiences (e.g., psychological wounds and also idealization), as well as a core archetypal part (Samuels et al., 1986). Complexes tend to powerfully grip a person with strong emotion and cause uncharacteristic behavior, problems in relationships, intrusive thoughts, and feelings of not being oneself. As a general rule, the more unconscious the complex, the more disruptive it is in the transference (Samuels, 1985b; Samuels et al., 1986).

Shadow. The shadow complex is comprised of everything in the unconscious, bad and good, that the individual finds to be unacceptable (Casement, 2006). Shadow material is often

projected onto the other during analysis, and may therefore be a determinant of CT (Samuels, 2006). Paradoxically, it is these shadow areas that tend to hold the greatest potential for healing and growth (Marlan, 2010).

Jungian Countertransference Theory

The analyst's personality. A main focus of the Jungian CT literature considers particular analyst traits or ways of being with patients that are essential for doing good analytic work. As a whole, these characteristics of the analyst facilitate the analyst's deep emotional/unconscious involvement in the analytic process, allowing for potentially useful CT reactions to emerge (Perry, 2008; Sedgwick, 1994, 2001; Wiener, 2009, 2010).

Analyst-as-wounded-healer. In his writings on CT, Jung (1951/1966, 1963/1989) drew upon the ancient myth of the wounded healer to illustrate the curative power of the analyst's suffering or pain—a framework still employed by many of today's Jungian CT theorists (Merchant, 2012; Sedgwick, 1994, 2001; Stein, 1984; Steinberg, 1990). The wounded healer model proposes that the analyst can only provide meaningful assistance when the patient manages to get to him in some way. Indeed, Jung (1963/1989) went so far as to say that "unless both doctor and patient become a problem to each other, no solution is found" (p. 143).

In the wounded healer model, the patient's difficulties must activate (or reactivate) the analyst's psychological conflicts, resulting in a condition of mutual woundedness characterized by transference-countertransference entanglements and intense CT reactions (Sedgwick, 1994). The analyst in this situation essentially tries to work on the client by working on himself —continuously addressing his own difficulties, or CT, in relation to the client (Sedgwick, 1994, 2001). As Jung (1931/1966) stated, "the doctor must change himself if he is to become capable of changing his patient" (p. 73).

The analytic situation wherein there is a deep intermingling of the analyst's unconscious with the client's unconscious is, according to Jungian theory, a necessary condition for transformative healing to occur (Sedgwick, 1994). The unconscious to unconscious bond is characterized by powerful, shifting transference-countertransference dynamics (or mutual projections) and thus brings to the forefront the notion of the analyst-as-wounded healer. The idea here is that the analyst comes to the analysis as someone who has experienced psychological wounding or suffering and has tried, with varying degrees of success, to heal or become conscious of his/her own wounds (Sedgwick, 1994, 2001). Summing up how the wounded healer model or concept works, Steinberg (1990) wrote:

> Some, often those who have had to spend the most time healing themselves, are called to psychological healing as a profession. Wounds, however, are seldom healed permanently. A vulnerability continues to exist [in the analyst] which can be activated by close proximity to the wounds of others [e.g., the client]. In the analytic work, the analyst's unconscious is penetrated by the patient's pain and the therapist becomes psychically infected by the projections to which he or she is exposed. Thus the healer is wounded again by taking on the illness of the other. This is especially the case when the patient's unconscious conflicts are in areas similar to those in which the therapist is scarred. (p. 27)

Put in more basic terms, Sedgwick (1993) stated that "the therapist's pathology enables the transference to occur, and the transference in turn facilitates the cure" (p. 83).

Jungian theory proposes that the reactivation or reconstellation of the analyst's wounds by the patient's projections form the basis for the analyst's CT reactions (Sharp, 1991). Once the analyst's wounds are activated, as Sharp (1991) simply puts it, "the analyst reacts, identifies what is happening and in one way or another, consciously or unconsciously, passes this

awareness back to the analysand (p. 150).” By reclaiming his/her own projections and developing a new relationship with the unconscious, the analysand or client’s *own inner healer* is activated and the client begins to heal (Sedgwick, 1994, 2001; Sharp, 1991). The same holds true for the analyst. In other words, the analyst reclaims projections that the analyst was unconsciously putting onto (or into) the client, thus facilitating a healing (sometimes, for the first time) or *re-healing* (on an even deeper level) of the analyst’s wounds (Sedgwick, 1994, 2001).

Another way of understanding the wounded healer concept is to view the analyst and client as hooked together in a mutual sharing of the psychic infection or illness—an idea proposed by Jung and elaborated upon by Sedgwick (1993, 1994, 2001). This sharing of the illness involves a kind of unconscious fusion whereby the analyst may, in fact, help to heal the client by the analyst engaging in self-work (and vice versa). As Sedgwick (2001) described:

> By [the analyst] understanding himself, by working on his ‘own hurt’ that is generated by the patient, the healing is effected in the patient. Whether it be his [the analyst’s] initial wounds of simply the patient’s rewounding of him, the therapist’s hurt and the patient’s are fused, so to speak in the unconscious or in a therapeutic space between them where the emotional problems crystallize. (p. 82)

This merging of the analyst’s wounds with the client’s wounds (if managed well by the analyst) is a healthy form of identification, a deep empathy essential to the analytic work (Sedgwick, 1994, 2001).

In terms of the connection between CT and the analyst’s wounds, on the one hand, the analyst must have a relatively good working relationship with the unconscious, or be conscious enough or sufficiently in touch with personal wounds, so as to not engage in CT behavior (e.g., over-identification with the client) that may harm the client or damage the analyst-client bond

(Jacoby, 1984; Sedgwick, 1994, 2001; Steinberg, 1990). This is where notions of CT management are appropriate to consider. On the other hand, the analyst must remain vulnerable to having his/her unconscious or latent wounds re-opened by the client (Sedgwick, 1994, 2001) or, as Jung (1946/1966) stated, taking a stance whereby the analyst "voluntarily and consciously takes over the psychic sufferings of the patient (p. 176)." Otherwise, the analyst runs the risk of becoming inflated by identifying too closely with the divine healer or savior archetype (Sedgwick, 1994; Steinberg, 1990). For healing to occur, the analytic field (at least at some point in the analysis) must become more even and balanced (Sedgwick, 1993, 1994); the analyst must keep in mind that the client, like the analyst, has an inner healer and that the analyst, like the client, is also in a hurt or wounded psychological state (Guggenbuhl-Craig, 1971; Sedgwick, 1994, 2001). For, as Jung (1931/1966) stated, "the doctor is as much 'in the analysis' as the patient" (p. 72).

Analyst receptivity. Jungian CT writings commonly highlight the therapeutic significance of analysts' openness to receiving projections or their capacity to cultivate a receptive attitude towards their patients (Cwik, 2010; Sedgwick, 1994, 2001; Wiener, 2009). Sedgwick (1994) describes how analysts must "clear the field" (p. 122) or enter into a kind of reflective-meditative state in which they are attuned to whatever emerges from the patient's and their own unconscious—what the noted Jungian analyst Michael Fordham (1993, 1995a) describes as "not knowing beforehand" (a phrase derived from Jung's 1946/1966 writings on the transference). In other words, as mentioned in the previous section, the analyst must be open or vulnerable to being wounded by the patient.

Today, more intersubjective Jungian scholars continue to explore this topic. For example, Wiener (2009) described how analysts must create a "shared mental space" (pp. 69-74) in the

imagination where something new and meaningful is allowed to emerge—a concept similar to Ogden's (1994) "analytic third" and the lesser-known "subtle body" (Schwartz-Salant, 1986 as cited in Schwartz-Salant, 1988) or "interactive field" in Jungian contexts (Schwartz-Salant, 1988, 1989, 1995). These imaginative uses of CT require the analyst to make all of himself/herself available to the unconscious, using feelings, thoughts, bodily responses, images, and dreams to understand the patient (Davidson, 1966; Schaverien, 2005, 2007, 2008; Wiener, 2009).

Jungian theory states that the intermingling of the analyst's unconscious with the client's unconscious allows for healing transformation to occur (Perry, 2008). This unconscious to unconscious interaction is thought to be characterized by powerful transference-countertransference dynamics, mutual projections, and, at times, periods of intrapsychic and interpersonal tension, struggle, and confusion (Perry, 2008; Samuels, 2006; Wiener, 2004). The unconscious to unconscious bond is also where the Jungian analyst's subjective state (e.g., the analyst's needs, fantasies, images, complexes) merges or combines with the client's subjective state to create a new, third factor—an intersubjective field or space between analyst and client (Wiener, 2004, 2009). It is in this *third area*, this area of unconscious fusion, where many Jungians have offered unique and interesting ideas about transference and CT (Carter, 2010; Schwartz-Salant, 1988, 1989, 1995; Schaverien, 2007, 2008; Wiener, 2009).

Most importantly is the Jungian idea that the archetypal transference is operating within the intersubjective field to try to facilitate the client's (and perhaps, the analyst's) psychological health and individuation (Carter, 2010; Perry, 2008; Samuels, 2006; Weiner, 2004). Another way of describing these archetypal processes is as the Self working through the transference-countertransference dynamic in order to stimulate and guide the individuation process (Colman, 2006; Stein, 2006a). Because the Self and other archetypes are transcendent

—and hence may behave in ways that do not adhere to the rules of logic, causation, space, and time, or may blur the lines between *inner* and *outer*, physical and mental, and *mine* and *yours* —the intersubjective field in Jungian models, compared to more mainstream models about intersubjectivity, tends to be characterized by numinous or transpersonal elements and dynamics (Carter, 2010; Perry, 2008; Stein, 2006a, 2006b). These transpersonal elements may manifest in the analyst's experiences of CT (Perry, 2008; Sedgwick, 1994, 2001). For example, the analyst may have synchronistic experiences in the CT, where something arises in the analyst that, although meaningfully or psychologically connected to something else, cannot be explained in logical or causal terms (Sedgwick 1993, 1994, 2001). Or, for instance, the analyst may experience CT images and fantasies that emerge in the service of individuation, yet cannot be explained as having *come from the client* or *come from the analyst*, nor be reduced to remnants from the client's or the analyst's personal history (Carter, 2010).

Schaverien (2007, 2008) proposed that when images, fantasies, or bodily sensations/perceptions arise in the CT that seem to have no obvious or easily identifiable source or meaning, analysts may benefit from using imaginative processes to discover what the image, fantasy, or bodily sensation/perception is trying to communicate—processes Schaverien (2007, 2008) likens to more traditional methods of Jungian active imagination. For example, the analyst may stay open to seeing what other, perhaps meaningfully-linked, images or fantasies spontaneously arise in the CT, remaining curious about these images or fantasies no matter how strange or threatening they may seem (Schaverien, 2007). By staying imaginatively open to the unconscious, *something entirely new* sometimes emerges in the transference-countertransference dynamic—what Jung would describe as the *transcendent function* (Carter, 2010; Schaverien, 2007; Sedgwick, 1994, 2001) This new or *third thing* may help relieve or loosen areas of

intrapsychic tension, conflict, or stuckness (e.g., between the client's conscious and the client's unconscious) and/or areas of interpsychic conflict and tension (e.g., between the client's unconscious and the analyst's unconscious), thus facilitating change from one psychological attitude or condition to another, healthier, psychological condition (Schaverien, 2007, 2008; Sedgwick, 1994, 2001). This psychological change tends to manifest as the client (and possibly analyst) experiencing a more open, fluid communication with the unconscious as well as an increased capacity to symbolize and tolerate ambiguity—all hallmarks of health and progress in individuation (Schaverien, 2007, 2008; Sedgwick, 1994, 2001; Stein, 2006a).

Analyst restraint. Another common theme focuses on the need for analysts, at times, to live through or submerge themselves in patients' experiences, neither engaging in defensive withdrawal nor interpreting feelings or images back to the patient. Sedgwick (1994) referred to this process as *incubating*, a concept similar to Plaut's (1956) idea of *incarnating* the archetypal image. By absorbing and containing projections, the analyst enters into a state of mutual unconscious identification in which he/she constantly works through the CT, monitoring for shifts in feelings and images (Sedgwick, 1994).

During incubation, healing is promoted by refraining from giving interpretations until the patient is ready or strong enough to have the material returned to him, for instance, the patient becomes able to trust in relationships and rely upon his unconscious to imagine, symbolize, dream, play, etc. (Plaut, 1966; Sedgwick, 1994; Wiener, 2009). Or, as touched upon before, the analyst-as-wounded healer takes on the client's projections, holds the projections, and refrains from giving the projections back to the client (i.e., making interpretations). Incorporating Kohut's theories into a Jungian frame, Jacoby (1984) described incubation as a process through which patients *use* the analyst to meet developmental (or individuation) needs by experiencing

parts of themselves with less anxiety (because they are now *in* the analyst). Simply put, the analyst becomes whatever the patient needs him to be at the time.

Analyst mental health. In order for the Jungian analyst to be able to use his own suffering to help others, he must have a sufficient degree of psychological health. Beginning with Jung (1913/1961, 1914/1961), who insisted upon training analysis for all prospective analysts [now a feature of all accredited Jungian Institutes (Casement 2010; Sherwood, 2010)] contemporary Jungians continue to discuss the merits of developing critical self-awareness and understanding (Sedgwick, 2001). In addition, the mainstream psychotherapy literature provides empirical support for self-awareness as a critical therapist factor in managing CT (Baehr, 2005; Hayes, Gelso, Van Wagoner, & Diemer, 1991; Van Wagoner, Gelso, Hayes, & Diemer, 1991).

In many different ways, Jungians have pointed out how the analyst needs to clean up his act or remedy his difficulties because unrecognized wounds or blind spots have the potential to severely disrupt analysis (Sedgwick 1994, 2001). In general, then, the more awareness the analyst has of his own blind spots (or shadow areas), and the more he has addressed these blind spots and continues to address them (in personal therapy for example), the more likely the analyst will be able to *use* his wounds to treat the client effectively and avoid causing undue harm to either the client or himself. From this standpoint, CT is therefore neither intrinsically bad nor good, but rather, its potential for usefulness or destructiveness depends on the degree to which the analyst is able to understand and manage his reactions to best serve the client—a perspective increasingly shared by many relational and Jungian therapists (Gelso & Hayes, 2007; Merchant, 2012; Sedgwick, 2001).

Dangers of Countertransference Work

The psychological and emotional intimacy required to do CT work within Jungian

frameworks, described by Sedgwick (1994) as going "a step 'beyond empathy'" (p. 109), compels Jungian analysts to walk a tightrope between facilitating and impeding analysis. These dangers or shadow aspects of CT typically manifest as some kind of empathic failure or boundary loss that ultimately stalls or diverts treatment.

Over-identification. Perhaps the most frequently discussed risk is the possibility of analysts identifying too closely with unconscious contents, particularly those of a powerful archetypal nature (Machtiger, 1995; Perry, 2008; Samuels, 2006; Stein, 1984; Steinberg, 1990). For example, Jung and others have warned of analysts over-identifying with the healer archetype, a condition causing the analyst to become psychologically inflated (e.g., I'm a savior, divine healer) and the client to remain stuck as being *just* the patient or the sick one in the relationship (Groesbeck, 1975; Guggenbuhl-Craig, 1971). Extreme forms of identification can even veer into dangerously psychotic realms—what Jacoby (1984) would call a *delusional* CT.

Jungians have also discussed the hazards of over-identification with clients' inner objects, often focusing on the development of psychological or even physical CT problems in the analyst (Jacoby, 1984; Proner, 2005; Sedgwick, 1993, 1994). For example, Stein (1984) mentions the possibility of analysts developing "psychic ailments like depression, anxiety, schizoid withdrawal" and suffering "invasions of unconscious figures and impulses" (p. 77). Furthermore, a number of Jungians have focused more on troublesome analytic relationship dynamics stemming from analyst's excessive identification. For instance, Lambert (1972, 1976, 1981), building on the work of Heinrich Racker (1968), described how the analyst may be primed for reenacting a negative relational pattern by identifying with a hostile inner object of the patient (thus experiencing the negative affects associated with this object/person). If these affects are not observed and contained, they may arouse the talion law—a retaliatory dynamic between patient

and analyst that destroys empathy and trust. Finally, Machtiger (1995) added that emotional overreactions can manifest as "being caught in an argument, being defensive, or becoming too sympathetic," calling attention as well to CT instances of "daydreaming profusely and having fantasies about particular patients" (p. 228).

Disengagement or withdrawal. In the mainstream CT literature, therapists' under-involvement or withdrawal from their patients is the most commonly discussed behavioral manifestation of CT (Gelso & Hayes, 2007; Hayes et al., 1998; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996), but is an aspect of CT that generally tends to be under-emphasized in Jungian writings. In his book on CT, however, Sedgwick (1994) detailed some personal examples of what he labeled "countertransference resistance"—experiences which tended to manifest as a loss of empathy and disengagement from his patients. Sedgwick often understood this kind of CT reaction as signaling a fear of fusing with his patients (in other words, accepting the patients' transference or illness, allowing himself to get emotionally invested) and thus making himself vulnerable to "patients' attacks" and "being batted around in crazy, oscillating feeling states" (pp. 93-94).

Intrusion of the analyst's psyche. Another CT danger theme described in Jungian writings is the interference of the analyst's personal wounds or psychological-emotional difficulties on the analytic process—what is often called an *illusory* (Fordham, 1957, 1960) or *neurotic* CT (Racker, 1968). The basic idea expressed here is that of the analyst's own unconscious, unresolved conflicts (e.g., shadow) getting reactivated by the patient and then projected onto the patient. This neurotic CT induces the patient to conform to the projections and, as a result, the analyst essentially loses his ability to *see* the patient or empathize with the patient's experience, hence bringing the analytic process to a halt (Wiener, 2009). Although the

wounded healer model proposes that some degree of the analyst projecting his/her own wounds into the patient is to be expected, the damaging effects of analysts' projections tend to manifest when the analyst is completely unconscious of the projections (often over a lengthy period in the analysis) or has failed to ever address or remedy the underlying wound (Sedgwick, 1994, 2001).

Breaking the frame. Goodheart (1984) explained how an analyst's shadow material may cause the analyst to act out or commit errors which effectively derail analysis—an idea introduced by Langs (1982). These errors often involved the analyst unknowingly altering the analytic frame (e.g., fees, time, location) in some way—a behavior generally thought to be a defensive, anxiety relieving maneuver. In the Goodheart-Langs model (as it has been referred to by Sedgwick, 1994), the patient's unconscious is constantly monitoring the analyst's unconscious and then making quasi therapeutic/supervisory attempts to get the analyst back on track (Goodheart, 1985 as cited in Sedgwick, 1994). Analysts must carefully listen for latent content in patients' associations that seem to point to what is wrong, while at the same time containing those personal conflicts that may be interfering with analysis (Goodheart 1980 as cited in Sedgwick, 1994). Put another way, analysts must continuously *hold the frame* in order to make progress.

Imposing needs and strivings. In the larger field of psychotherapy, unrecognized or unmet needs of the psychotherapist are considered to be a source or origin of CT reactions (Gelso & Hayes, 2007; Hayes & Gelso, 2001). Jungians have also recognized that analysts' unconscious desires may have influence the transference-countertransference field. For example, Stein (1984) described how analysts' need for power may cause him to adopt a dominating or punitive stance towards the patient. Jacoby (1984) discussed the negative impact of analysts' strivings for therapeutic success or money, the need to live unlived parts of his/her own life

through the patient, the desire to possess someone, and the need for love or sex. Finally, Machtiger (1995) mentioned how analysts' unconscious attempts to avoid a therapeutic task can sometimes result in hasty referrals for psychotropic medications.

Desire for personal help. Jungians have also discussed how the analyst's unconscious desire for self-healing may hinder or even reverse the analytic process (Groesbeck, 1975; Merchant, 2012; Stein, 1984). In these cases, the analyst (not in touch with his own hurt) projects his wounds onto the patient, and the patient, identifying with the projections, presents the analyst's own unconscious suffering back to him. The analyst believes that he is treating the patient's problems, but he is actually working on his own difficulties *through the patient* (Stein, 1984). Taken a step further, analysts' projections may actually induce the patient into trying to cure the analyst of his psychological conflicts—a somewhat radical idea first proposed by the psychoanalyst Harold Searles (1975). Although some measure of this phenomenon of reversal is expected in Jungian analysis as a being a normal part of the dialectical or wounded healing process, it can potentially veer into abusive territory by burdening the patient with undue suffering and responsibility (Guggenbuhl-Craig, 1971; Sedgwick, 1994; Stein, 1984).

Summary of Jungian CT Theory

The key component of CT as defined in the current study is the activation of unresolved conflicts or psychological wounds in the analyst—an idea supported by the mainstream psychotherapeutic literature, especially those of a relational bent (Gelso & Hayes, 2007)—and also having credence among today's Jungians (Sedgwick, 1994, 2001). Invoking the concept of the wounded healer, this definition of CT purports that analysts' wounds may facilitate (e.g., by identifying or empathizing with the patient), as well as hinder analysis (e.g., by identifying *too much* with the patient). A major determining factor in this regard is how well the analyst is able

to manage CT. Jungians highlight the potential helpfulness of analysts' receptivity and restraint in session, as well as resolution of their own personal problems, at least enough so that they do not impinge upon the patient. Furthermore, Jungians have also stressed the archetypal dimension of the transference and its twofold capacity to be healing or destructive, with the outcome greatly depending upon how well the analyst relates to, manages, and navigates these powerful dynamics.

Finally, a number of Jungians have theorized about the transferential field from what may be considered a more intersubjective standpoint. These Jungians generally see CT as being a deeply imaginal process that is located in a shared-space, a third area somewhere in-between analyst and patient. CT reactions in these cases are often considered in terms of felt or bodily experiences that may be difficult to accurately describe (Schaverien, 2007, 2008; Schwartz-Salant, 1995; Stone, 2006; Wiener, 2009).

Empirical Research

Both Jungian and non-Jungian CT research are reviewed in this section. Because only three Jungian empirical studies relevant to the current study were found (i.e., Dieckmann (1974, 1976 [two reports, one study]), Samuels (1985a) and Catlin (2006)), all will be examined in detail. Before doing so, however, it is worth a brief mention that my literature review uncovered three outcome studies that, limitations notwithstanding (i.e., low recruitment/participation, weak retrospective study design, etc.), provided some empirical support for the benefits of Jungian analysis (Keller, Westhoff, Dilg, Rohner, & Studt, 2002; Mattanza, Hurt, & Schwandt, 2004; Rubin & Powers, 2005).

Jungian research. Jungians thus far have a fairly meager foundation of CT research on which to stand. Nonetheless, Jungian CT research has shown CT to be a rather common and

potentially potent clinical tool (Dieckmann, 1976; Samuels, 1985a). Findings have also highlighted the enormous complexity of the CT phenomenon in terms its derivations (Dieckmann emphasized the role of the analysts' psyche while Samuels, the patients'), the possible multidimensionality or multi-layeredness of CT (with particular emphasis on the archetypal dimension), and the tendency for CT to be experienced in a variety of different forms or modalities (e.g., somatic, feeling, fantasy). Finally, as a whole, Jungians who have researched in the area of CT have stressed the dialectical or mutual nature of working in the transference-countertransference field, with Dieckmann and Catlin in particular having stressed the clinical significance of the analyst's subjectivity. I will now consider each study in depth along with a critical review of the findings.

Dieckmann. A group of Jungian analysts in Germany conducted a three-year empirical study of CT. Dieckmann (1974, 1976) and each of his four colleagues recorded their own spontaneous associations to patient material in session, while simultaneously noting what the patient was experiencing at that given moment. These dual notations, which consisted of the analyst's unconscious material associated with that of the patient's unconscious material, were then analyzed in group sessions by the same analysts.

The most striking finding was that in nearly every case, a remarkably complete and meaningful connection emerged between the analyst's chain of unconscious associations and the patient's (Dieckmann, 1976). In fact, these chains were so in synch with one another that analysts' associations frequently foreshadowed that of patients even though the material was not always verbally discussed in session. This high degree of synchronicity was especially salient in sessions in which the patient presented an archetypal dream to the analyst—one characterized by the presence of mythological motifs and, most importantly for the investigators, strong or intense

emotion. Moreover, analysts' self-analysis—namely their processing of CT in the group—often had a corresponding healing effect on the patient whose case was being considered. Finally, nearly all instances of CT could ultimately be traced back to some kind of wound originating in the analysts' personal history. Analysts' anxiety in the CT contributed widely to the problem of resistance and was also related to long-standing personal difficulties in the analyst.

Overall, Dieckmann (1976) concluded that these findings provided evidence for the workings of an underlying archetypal dimension in the transference (e.g., the Self) that is ultimately responsible for synchronizing chains of associations between analyst and patient and guiding the analytic process towards psychic growth—a fundamental idea of Jungian theory (for illustrative examples see Dieckmann, 1974, pp. 73-74, 76, 78-80; 1976, pp. 33-35 and Blomeyer, 1974). Dieckmann also tentatively postulated that perhaps humans possess a yet-to-be discovered ancient perceptual system that can explain, on a biological level, how these synchronistic events between two people can occur (a phenomenon that Dieckmann argued resembles what you might call E.S.P.).

Critique of study. A major strength of Dieckmann (1974, 1976) is the attempt to investigate the *unconscious* aspects of the transference-countertransference field—a dimension oft cited as critical, yet notoriously difficult to study (Perry, 2008). To this end, the authors employed a number of techniques aimed at strengthening the validity of the study such as attending to their own unconsciouses and recording whatever material, no matter how subtle or irrational, cropped up. According to Dieckmann, this was a difficult process but one that analysts seemed to get better at over time. Investigators also considered the interactive and oftentimes fleeting nature of CT manifestation by noting patient material alongside the analysts' *in the moment*. Based on the data, Dieckmann argued that these momentary and sometimes subtle CT

reactions often prove to be quite clinically significant, confirming what many analysts have likely experienced in their own clinical work. Finally, the use of a processing group to help make sense of emergent CT phenomena was a strength in that the participating analysts did not need to rely on self-report and retrospective recall—methodologies which are likely to suffer from self-serving biases, distortions, and inaccuracies.

A potential drawback of the Dieckmann (1974, 1976) study is the fact that the researchers were also the participants. The rather insular environment of the processing group introduces concerns about confirmatory biases in data gathering and interpretation, an unbalanced emphasis on dream material over other CT manifestations, as well as biased conclusions about the decisive role of the Self archetype in shaping and guiding transference-countertransference interactions. The credibility of the findings may have been enhanced had Dieckmann provided a more detailed description of the study methods (e.g., what actually took place in the process groups? How systematic was the procedure?), attempted to account for underlying assumptions and biases, and perhaps presented a comprehensive overview of the data, including themes with exemplars, in tabular format.

Samuels. Andrew Samuels (1985a) explored *syntonic* CT (a term introduced by Fordham, 1957, 1960, 1995b), defined as the analyst's reactions derived from the patient's unconscious communications. In syntonic CT, the analyst experiences parts of the patient's inner world *in himself* and thus *uses* this information to better treat the patient. More specifically, Samuels investigated what he proposed were two types of clinically-usable CT: *reflective* and *embodied*. *Reflective* CT involves the analyst experiencing parts of the patient's current internal state or mood (like depression)—even though the patient himself may be unaware—while *embodied* CT involves the analyst experiencing a long-standing inner object of the patient, such

as the patient's experience of a depressed mother. As its name implies, embodied CT is often manifested physiologically in the analyst.

In order to test the hypothesis that these two forms of CT indeed exist, Samuels (1985a) asked 26 Jungian therapists (all past supervisees) to submit examples of CT reactions believed to have originated from patients' unconscious conflicts. They were also asked to label each CT as being either reflective or embodied, comment on how this experience had affected their work, and say how the patient may have evoked these feelings in them.

Samuels (1985a) found that out of 76 examples of CT, 46 percent were labeled embodied and 54 percent reflective. Noting respondents' accurate use of the reflective and embodied classification, Samuels interpreted these findings as confirmation of his hypothesis. Samuels also described how these CT responses also emerged into distinct categories of bodily and behavioral responses, feeling responses, and fantasy responses.

Based on these findings, Samuels (1985a) proposed that the complexities of the transference-countertransference field could be usefully explained through the lens of the *mundus imaginalis* or imaginal world—a term used by the French scholar Henry Corbin (1972, 1983 as cited in Samuels, 1985a). In essence, the mundus imaginalis can be thought of as a shared third area which brings together those rather spurious distinctions between the interpersonal and intrapsychic, body and image, inner and outer, mine and yours (Samuels, 1985a).

Critique of study. As Samuels (1985a) stated, the main thrust of his study was to test his reflective/embodied CT model by inviting analysts to report on their CT experiences. The basic assumption was that if other analysts (besides himself) were able to give real-life examples of CT experiences that they regarded as being unconscious communications from the patient—and,

importantly, draw distinctions between reflective and embodied—then his model would be supported (that is, reflective and embodied CT phenomenon indeed exist and that it's clinically useful to distinguish one from the other).

Samuels (1985a) argued that an inductive approach was the best way to test his model. However, by stating a priori hypotheses and imposing an a priori classification scheme on the data (thus ensuring CT was viewed as belonging to one of his two favored types), Samuels in fact violated the fundamental principles of an inductive approach.

Samuels (1985a) also likely introduced demand characteristics by choosing participants who were not only former clinical supervisees of his, but who also participated in his seminars on his proposed reflective/embodied CT model. A reasonable assumption is that participants' prior experience with Samuels, coupled with potentially leading characteristics of the study design, probably skewed data in a positive or confirmatory direction. Moreover, Samuels appeared to be the only person involved in data analysis and interpretation—the data, in other words, were never checked by more independent auditors and may therefore be influenced by personal biases.

Finally, Samuels (1985a) provided no account of many seemingly important methodological details, particularly with regards to data gathering and analysis. For example, how did Samuels determine, in the end, which CT descriptions were reflective and which were embodied? Did he simply agree with participants' classifications of their own CT or were distinctions based on specific criteria (and if so what were they)? How were CT submissions that "could be said to be both reflective and embodied" (p. 55) resolved? Unfortunately, aside from including one example of each type of CT (see pp. 55-56), all one has to rely on are rather vague statements such as: "It is abundantly clear that these participants could see how to use such a

classification of countertransference" (p. 55). In light of all of these methodological problems, the credibility of Samuels' findings—and thus their applicability to the current study—is seriously compromised.

Catlin. More recently, Catlin (2006) investigated what happens in the early phase of Jungian analysis, including how the analytic relationship is established and what analysts think are the unique and essential components of the analytic process. Catlin did this by interviewing 12 certified Jungian analysts about their experiences of becoming and working as analysts. Part of the interview involved asking each analyst to describe his or her work with an actual client in the first year of analysis.

Data were analyzed using a modified version of Consensual Qualitative Research (CQR). This method basically entailed the joint work of a research team that boiled down participants' responses into thematic categories. Overall, the frequency of each theme's occurrence indicated its salience in the data.

The most salient finding was participants' emphasis on their personal Jungian analysis as playing a vital role in their analytic training and motivating them to become Jungian analysts themselves. Analysts also viewed their personal analysis as instrumental in their ability to do good analytic work—describing how self-awareness stemming from analysis helped reduce negative effects emanating from their own conflicts or needs. As one analyst in Catlin's (2006) study said, "I think you will have had to go through it [analysis] yourself, and suffer your way through some crucial issues. I do not know of a really worthwhile therapist who has not in a certain sense become a wounded healer" (p. 111).

Results also showed that most analysts saw attending to the analytic relationship as being an essential component of Jungian analysis, with transference-countertransference dynamics

specifically noted by some as an important focus (Catlin, 2006). In addition, analysts described the dialectical nature of the analytic relationship as being a unique element of Jungian analysis, emphasizing the personal changes analysts may experience as a result of their deep involvement with clients. Finally, in terms of how analysts go about establishing the analytic process, participants typically said that they don't think of themselves as *doing* anything in particular, but instead are concerned with *ways of being* with clients (e.g., listening symbolically, being empathic and genuine).

Critique of study. The high fidelity use of CQR—a methodologically rigorous approach to qualitative research—strengthened the credibility of Catlin's (2006) findings. Further, the intensive exploration of the experience of seasoned analysts enhanced the clinical meaningfulness or relevance of the results.

Catlin's (2006) findings (as she noted) have very limited generalizability due to her use of a qualitative methodology and related factors such as the participation of a small number of analysts trained at the same institution (C. G. Jung Institute of Chicago). Catlin also surmised that by limiting her focus to examining just the early stages of analysis, she may have been unable to fully access or capture some of the (reportedly) unique aspects of Jungian work, elements that perhaps are more likely to manifest during later stages (e.g., archetypal material, synchronistic events, and symbolic expressions). Lastly, Catlin reflected on possibilities that an over-reliance on telephone interviews as well as an absence of client reports on the analytic process may have limited her findings.

Non-Jungian Research

Research on CT has gained momentum in the past 25 years, allowing for several recent reviews of the CT empirical literature (see Fauth, 2006; Gelso & Hayes, 2001, 2002, 2007;

Hayes et al., 2011; Rosenberger & Hayes, 2002b). The bulk of this research has thus far consisted of analogue studies (e.g., Fauth & Hayes, 2006; Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1991, 1993; Latts & Gelso, 1995; Lecours, Bouchard, & Normandin, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Van Wagoner et al., 1991; Yulis & Kiesler, 1968), along with a relatively small number of qualitative studies (e.g., Baehr, 2005; Gelso, Hill, Mohr, Rochlen, & Zack, 1999; Hayes et al., 1998; Williams, Judge, Hill, & Hoffman, 1997; Hill et al., 1996; Williams, Polster, Grizzard, Rockenbaugh, & Judge, 2003). As previously mentioned, however, there now seems to be a growing trend in the use of qualitative methods to investigate CT, especially in the area of dissertation research (e.g., Cooper-White, 2001; Davidtz, 2007; Kholocci, 2008; Pitre, 2008; Weisshaar, 2008).

As a whole, CT research has moved the psychotherapy field towards the beginnings of an evidence-based conception of CT that may inform clinical practice (Gelso & Hayes, 2007). The following highlights some of the main findings from the extant literature, which incorporates the finding from studies from a variety of research traditions (e.g., field, experimental, and qualitative).

Summary of non-Jungian research. Overall, CT has been shown to be a ubiquitous phenomenon in psychotherapy (Gelso & Hayes, 2007) that most fundamentally emanates from unresolved psychological conflicts, vulnerabilities, or wounds within the therapist (Hayes et al., 1998; Rosenberger & Hayes, 2002b). These conflicts tend to be rooted in therapists' early experiences and may involve a host of issues related to unmet needs, family of origin, parental or romantic roles, and professional self-concept (Baehr, 2005; Gelso & Hayes, 2007; Hayes & Gelso, 2001; Hayes et al., 1998). Research has also demonstrated that although CT can be triggered by a number of different patient and therapy factors such as attachment style (Mohr,

Gelso, & Hill, 2005), sexual orientation (Gelso et al., 1995; Hayes & Gelso, 1993), and termination (Boyer & Hoffman, 1993; Cruz & Hayes, 2006 as cited in Gelso & Hayes, 2007), these triggers are best understood within the interactive matrix of the patient-analyst dyad (in other words, how triggers interact with analysts' vulnerabilities and conflicts). Gelso and Hayes (2007) have referred to the interaction of triggers and psychological wounds as the *countertransference interaction hypothesis*—a theory supported by number of empirical studies (see pp. 44-45, 131-132 for detailed discussion).

In terms of understanding how CT is manifested, researchers have typically examined the affective, cognitive, and behavioral reactions of therapists (Gelso & Hayes, 2007). The majority of studies have shown anxiety to be a salient indicator of CT (Gelso et al., 1995; Hayes et al., 1998; Hayes & Gelso, 1991, 1993), while others have uncovered a wider range of CT affects such as anger, sadness, boredom, envy, and guilt (Baehr, 2005; Hayes et al., 1998). CT has also been implicated in therapists' inaccurate recall of patient material (Cutler, 1958; Hayes & Gelso, 2001), misperception of how similar or dissimilar patients were to themselves (McClure & Hodge, 1987), alterations in treatment approach (Hayes et al., 1998; Lecours et al., 1995), and therapist negative self-perception (e.g., judging oneself to be less attractive, trustworthy, and effective; Rosenberger & Hayes, 2002a). Finally, the most frequently investigated behavioral manifestation of CT has tended to be some form of therapist under-involvement (e.g., avoidance or withdrawal; Hayes et al., 1998; Hill et al., 1996) or over-involvement with patients (e.g., being over-protective or overly sympathetic; Gelso et al., 1995; Gelso et al., 1999), with some studies suggesting that male therapists are more likely to pull back while female therapists are more likely to draw closer when their unresolved conflicts are triggered (Fauth & Hayes, 2006; Hayes & Gelso, 1991; Peabody & Gelso, 1982; Rosenberger & Hayes, 2002a).

CT research often rests on the basic assumption that unmanaged internal CT ultimately results in a counter-therapeutic behavior—an acting out of CT—whereas successfully-managed CT ultimately contributes to better therapeutic outcomes. In a recent meta-analysis addressing the relationship between CT management and outcome, Hayes et al. (2011) indeed found some indirect empirical support for the hypothesis that effective CT management enhances the psychotherapeutic process. At the same time, the authors noted that there is a lack of direct evidence supporting the hypothesized relationship between CT management and outcomes.

Several therapist characteristics have emerged as key components of effective CT management. For example, therapists who possess both a high awareness of their CT feelings as well as a clear theoretical framework from which to understand these feelings tend to be most effective in managing their CT (Latts & Gelso, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987). Other studies have implicated therapists' empathy (Baehr, 2005; Hayes, Riker, & Ingram, 1997; Peabody & Gelso, 1982), self-insight (Hayes et al., 1991; Van Wagoner et al., 1991), anxiety-management abilities (Fauth & Williams, 2005; Gelso et al., 1995; Hayes & Gelso, 1991; Yulis & Kiesler, 1968), and degree of self-integration (i.e., the ability to differentiate self from other, intactness of character structure; Gelso et al., 1995; Van Wagoner et al., 1991) as important in CT management. A logical extension of these findings is that therapists who are able to develop the aforementioned traits (e.g., empathy, self-integration, self-insight) through personal therapy and/or supervision, for instance, will be better positioned to use their conflicts and vulnerabilities to help, rather than harm, their clients (Baehr, 2005; Gelso & Hayes, 2007).

Baehr's (2005) grounded-theory study stands out among the CT management literature as being particularly relevant to the current investigation. In order to develop a coherent model of

CT management grounded in experiential reports, Baehr interviewed 12 experienced psychotherapists about how they dealt with CT reactions to clients who achieved some measure of success in therapy.

Baehr (2005) found that CT reactions generally stemmed from therapists' unmet needs or wounds and were often linked to vulnerabilities in self-concept, for instance in situations when therapists' clinical competency felt threatened. Therapists' empathy, for clients' as well as the therapist's suffering, emerged as both a potent facilitator and product of successful CT management. At times, empathic connections were deepened when therapists shared their personal vulnerabilities with clients, resulting in enhanced client self (and other) awareness and acceptance.

Unlike other CT management studies, Baehr (2005) investigated what therapist behaviors were helpful in managing CT as well as how therapists were affected by CT work. Therapists reported on a variety of useful self-care practices ranging from taking a break between clients to engaging in personal therapy. Overall, identified self-care practices involved some kind of nurturing relationship with the self or others and reflected therapists' commitment to offering their clients a therapeutic experience. Most therapists described having undergone personal and/or professional developments in relation to their engagement with CT over time, resulting in decreased defensiveness, increased empathy, deepened experience of emotion, and increased acceptance of life's struggles.

Finally, research has highlighted other characteristics of CT that are worth mentioning. For example, therapists tend to experience positively valenced CT reactions towards their clients that may be beneficial (as one might expect) but may also be as disruptive as more negative forms of CT if unmonitored and unmanaged (e.g., empathy leads to over-involvement or caring

too much; Friedman & Gelso, 2000; Hayes et al., 1998; Ligiero & Gelso, 2002). Moreover, CT reactions are not always experienced as intense emotional reactions (e.g., anger and lust) but may also be felt as low-intensity reactions towards clients (e.g., boredom, low interest/engagement, and tiredness; Gelso & Hayes, 2007).

Critique of non-Jungian research. CT research as a whole has been limited by great variability in how CT has been defined (or failed to be defined) and measured across studies. However, CT experts have now begun to synthesize the existing research into a more coherent model that emphasizes core elements of the CT phenomenon (e.g., importance of therapists' subjectivity in the origination of CT and the mutually-interactive nature of CT) and calls attention to gaps in the literature (e.g., lack of qualitative studies and therapy outcome studies; Gelso & Hayes, 2007). Furthermore, results from analogue studies (the bulk of CT research) are limited in terms of their applicability to clinical practice—although improvements in methodological procedures have taken place that more closely resemble real life therapy situations. Finally, many of the fundamental assumptions on which contemporary or relational CT theory rests need stronger empirical support. For example, as previously discussed, there is very little direct evidence supporting the notion that better CT management leads to better outcomes (Hayes et al., 2011).

Implications of Extant Research for the Current Study

Research, as a whole, has provided evidence that therapists' unresolved conflicts or psychological wounds are critical in defining CT reactions (Baehr, 2005; Cutler, 1958; Dieckmann, 1976; Hayes et al., 1998) and that the analyst's working through of these wounds can be a powerful clinical tool (Baehr, 2005; Catlin, 2006; Gelso & Hayes, 2007). In addition, empirical support has been found for the mutual or interactive nature of the

transference-countertransference phenomenon (Field, 2003; Gelso & Hayes, 2007), the centrality of therapists' subjective reactions when considering the subtleties and complexities of CT (Dieckmann, 1976; Gelso & Hayes, 2007; Hayes et al., 1998), and the fact that some therapists may be changed by doing CT work (Baehr, 2005).

Although this research signifies a major step forward in our empirical understanding of CT, substantial information gaps exist, some of which the current study will address. Most important is the need for a better understanding of *how* therapists' psychological wounds impact the therapeutic process and *how* management of CT reactions may lead to better outcomes (in other words, how wounded healers really heal) a clinically relevant, yet woefully under-investigated area (Baehr, 2005; Fauth, 2006; Gelso & Hayes, 2007; Hayes et al., 2011; Sedgwick, 1994, 2001; Zerubavel & Wright, 2012). The current study will explore these gaps by taking an in-depth look at how Jungian analysts understand and manage CT in practice, focusing on largely unexamined (yet crucial) dimensions of therapists' CT experiences of CT involving emotion and meaning-making (Fauth, 2006). Further, this study's phenomenological approach (that is, being open to whatever emerges from participant descriptions) is consistent with recommendations that today's CT studies adopt a broad conception of CT (e.g., affective, cognitive and behavioral therapist reactions) as opposed to defining CT in narrower terms (Fauth, 2006), account for both negative *and positive* CT valences (Fauth, 2006; Gelso & Hayes, 2007), and consider experiences of CT management failure that perhaps even resulted in harm to the client (Baehr, 2005).

Method

Research Design

The current study used a qualitative research approach, Interpretative Phenomenological

Analysis (IPA), to examine Jungian analysts' experiences of CT. Semi-structured interviews were used to collect the data. The primary goal of IPA is to acquire a rich, detailed understanding of what it is like for an individual to experience a specific situation or event (Smith & Osborn, 2008). In other words, as a phenomenological method, IPA is concerned with *meaning*, understanding how someone makes sense of his or her unique, lived-experience of a particular phenomenon (Smith, Flowers & Larkin, 2009). The IPA approach therefore fits well with the present study's aim of taking an in-depth look at analysts' experiences of managing their subjective reactions to a particular client.

Smith and Osborn (2003) note that "IPA is especially useful when one is concerned with complexity, process or novelty" (p. 53). The current study met all three criteria in that it focused on exploring the intricacies of the transference-countertransference dynamic in the largely unstudied, multifaceted field of Jungian analysis. More specifically, this study involved a close examination of a number of novel, complex, and potentially important components of CT, such as the analyst's personality and the archetypal dimension of the unconscious.

Investigator bias, credibility, and reliability. IPA unavoidably involves the researcher's subjectivity and personal biases in the investigatory process, most notably when it comes to data collection and interpretation. Put another way, the meaning of participant narratives is inevitably co-constructed or affected by ideas, feelings, and judgments that the researcher brings to the interview (Smith & Osborn, 2008). On the one hand, this personal involvement has its positive side in that it may allow for a deeper, more intimate, and nuanced exploration of the phenomenon under investigation. On the other hand, this level of engagement also has the potential to interfere with the researcher's interpretation of participant narratives, clouding what the participant really meant to convey and moving away from understanding the

essence of the phenomenon being studied (Giorgi & Giorgi, 2008; Mertens, 2005).

Accordingly, several steps were taken in order to actively enhance the transparency and credibility of the study by making researcher biases more explicit and taking steps to limit the influence of these biases on the research process. The first involved explicitly acknowledging, or bracketing, the investigator's assumptions and preconceptions. This transparency allowed for critical analysis of the extent to which researcher biases may have influenced the analysis, and was intended to increase overall transparency and credibility of the findings (Smith & Osborn, 2008). The second step, called a member check, involved inviting participants to review interpreted data in order to ensure that the investigator accurately captured what they meant to convey (Mertens, 2005). The final step involved enlisting a second coder to audit portions of the data analysis. The second coder essentially acted as an external check on thematic content gleaned from participant narratives and helped the investigator to notice and manage his biases (Smith & Osborn, 2008).

Personal biases that may possibly impinge upon this study, as far as I am aware, stem largely from my passionate interest in Jungian psychology. More specifically, my overall positive experience of engaging in personal therapy with a Jungian-influenced therapist has undoubtedly influenced my tendency to hold Jungian therapy in high regard as a powerful mode of treatment. My therapy experience has subsequently led to a self-immersion in Jungian writings, having the combined effect of fueling my absorption in this topic and, to a great extent, shaping this project. Although this immersion is not a bad thing per se, it is important for me to be mindful of how my fascination with Jungian psychology could hamper critical thinking or impede upon a fair, balanced approach to data collection and analysis—for example, by unwittingly deemphasizing non-Jungian perspectives, casting Jungian therapy in an

exaggeratedly positive light, or perhaps, being overly attuned to the archetypal or spiritual in therapists' responses. Finally, I am also aware that I expect most analysts to have had the experience of their own stuff (e.g., personality traits, conflicts, and pathologies) affecting the transference-countertransference dynamic, as well as having been meaningfully changed or transformed by the patient they choose to discuss.

Participants

Eligibility. Persons eligible to participate in this study were Jungian analysts living in the United States who have completed training at any of the C.G. Jung Institutes in the United States or abroad that have been accredited by the International Association of Analytical Psychology (IAAP). The IAAP training requirement was the same as in Catlin's (2006) study. Eligible participants were also currently in practice and willing to discuss their experiences of CT regarding their work with a former client.

Based on these eligibility criteria, participants were expected to have the following characteristics in common. First, certified Jungian analysts were expected to have formally studied foundational elements of Jungian therapy critical to the current study, such as unconscious dynamics between client and analyst as well as transpersonal dimensions of the psyche. Secondly, in terms of actual practice, it was reasonable to assume that this group's day-to-day clinical work was significantly influenced by Jungian thought. Third, it was anticipated that all Jungian analysts had undergone a lengthy personal analysis as part of their training or training analysis (Catlin, 2006). Taken together, these attributes should have contributed to the formation of a relatively homogenous group of participants who were able to provide relevant, rich descriptions of CT from the perspective of practicing Jungian analysts. These characteristics may have also been an asset when it came to gathering detailed information

about how therapists dealt with these very personal, and oftentimes quite difficult, CT reactions.

Sampling. Purposive sampling was used to identify potential participants. The purposive sampling procedure was appropriate for the present study because of IPA's highly personal and idiographic nature, where the focus is on capturing the essence of a phenomenon by exploring in-depth, first-hand experiences of a small number of individuals (Smith & Osborn, 2008). Purposive sampling involves the careful selection of participants who share specific characteristics, in this case the aforementioned eligibility requirements, assumed to be important for addressing the research question(s) (Mertens, 2005). Smith and Osborn (2008) claimed that a reasonable sample size for student projects using IPA is generally five or six participants; however, this did not preclude a larger or smaller sample size. The goal of the current study was to interview six participants.

Recruitment. Potential participants were identified using three strategies: (a) contacting certified Jungian analysts who were either personally known by the investigator or who were recommended by the investigator's colleagues as possible participants; (b) contacting certified Jungian analysts who were part of either the New England Society of Jungian Analysts (NESJA) or the New York Association for Analytical Psychology (NYAAP) by having accessed membership lists displayed online (www.cgjungboston.com; www.nyaap.org/analyst-directory); (c) using a snowball recruitment strategy in which participants nominated other analysts who were interested in participating (Mertens, 2005). Analysts living or working in closer proximity to the primary investigator's home were given preference in order to increase the likelihood of in-person interviews.

Two forms were e-mailed or mailed to potential participants: (a) the Participant Recruitment Announcement (see Appendix A), which included a brief study description,

including information about eligibility criteria, compensation for participation ($25 gift certificate for Amazon.com) and confidentiality issues associated with the current study and (b) the Semi-Structured Interview Protocol, which included a brief interview introduction and interview questions (see Appendix B).

Individuals who were eligible for and had an interest in the study were asked to contact the investigator via e-mail or telephone. The investigator and potential participant then engaged in a phone conversation during which the terms of the study were reviewed and the investigator confirmed that the individual met the inclusion criteria.

If the individual decided to participate, a mutually agreed-upon date and time were chosen to conduct the interview. As mentioned earlier, preference was given to in-person interviews over telephone interviews. The investigator then e-mailed or mailed (depending on the participant's preference) four forms along with a brief *thank you for agreeing to participate* letter to the individual: (a) the Demographic Questionnaire (see Appendix C), which included questions about the analyst's training, professional practice, and personal analysis; (b) the Client Information Questionnaire (see Appendix D), which included brief questions about working with the client to be discussed (mostly regarding durations of analytic work, the challenging period, etc.) and (c) the Consent Form (see Appendix E). The Informed Consent form included detailed information about study risks and benefits, steps taken to protect confidentiality, and participant rights to withdraw from the study and request study results.

In-person interviews. Prior to the start of the interview, the investigator collected a completed (a) Demographic Questionnaire, (b) Client Information Questionnaire and (c) signed Consent Form from the participant. If the participant had not yet completed these forms at the time of the investigator's arrival, time to do so was given before the interview began.

Telephone interviews. For those participants who opted for a phone interview, the investigator mailed a hard copy of (a) Demographic Questionnaire, (b) Client Information Questionnaire, and (c) Consent Form to the participant along with a self-addressed stamped envelope well in advance of the interview date. The participant was asked to complete the demographic form, read and sign the Consent Form, and mail both documents back to the investigator prior to the interview date.

Participant demographics. Six analysts (4 Males; 2 Females) were interviewed for this study. Three analysts were interviewed in-person and three analysts by telephone. The Highest Education Level of participants was: 1 M.D.; 2 Ph.D.; and 3 Master's-level. Participants completed their Analytical Training at Jungian Institutes in Boston, Chicago, New York (2 analysts), Texas, and Zurich, Switzerland. In addition to Jungian thought, participants reported a number of influences on their work with clients including: Attachment Theory, Buddhism, Christianity, Dialectical Behavior Therapy, Enneagrams, Evolutionary Psychotherapy, Family Systems Theory, Gestalt, Hakomi, Kleinian, and Object-Relations Theory/Therapy, Mindfulness, Mysticism, a variety of Post-Jungian and other Neo-Freudian Thought, and Sufism.

The mean age of analysts in this sample was 69.3 years. The median age was 68 years, with a range from 58 – 90. The mean number of years ago analysts completed their Analytical or Jungian Training was 14.7, median was 7.5 years, with a range from 2 – 34. The mean number of years analysts spent in practice before completing their Analytical Training was 5.5, with a range from 0 – 10. The mean number of years analysts spent practicing after completion of Analytical Training was 14.3, the median was 7.4 years, with a range from 2 – 33. The mean total number of years analysts participated in their own personal therapy or analysis was 14.7, the median was 13 years, with a range from 5 – 27. In addition to having received Jungian analysis, analysts also

reported having received gestalt, psychodynamic, and family systems therapy. Race/Ethnicity data were collected, but will not be reported to preserve participant privacy.

Client demographics. Participants described their analytic experiences with six clients (1 Male; 5 Females). The mean age for clients at the beginning of their analysis was 45 years, with a range from 38-52. The mean total length of time clients spent in analysis with this particular analyst was 9.2 years, the median was 5.7 years, with a range from 1.5 - 30. The mean time since termination of the treatment under consideration was 6.4 years, the median was 4.5 years, with a range from 1.5 – 17.8. The mean difficult or challenging period with the client began 1.3 years into analysis, the median was .3 years with a range from 0 [or immediately] – 6. The mean difficult of challenging period with the client lasted 3.1 years, the median was 2.1 years, with a range from .5 – 8. Finally, two analysts reported slight improvement in analysis for the client under consideration; two reported moderate improvement; and two reported great improvement.

Data Collection

Semi-structured interview. The goal of the interview was to acquire phenomenological descriptions of analysts' CT experiences during therapy with a specific client. Participants were encouraged to ask questions and express any concerns that they may have. All interviews took place in a private location.

Each semi-structured interview lasted 60-90 minutes and was audio-recorded and transcribed verbatim upon completion by the primary investigator. The semi-structured format meant that the researcher used predetermined questions to guide the inquiry as opposed to adhering to a rigid structure (Smith & Osborn, 2008). In other words, the main questions listed in Appendix B were asked of all participants, but the investigator also used prompts as needed to

clarify answers and follow lines of thought that seemed important, and germane to the original question, in gathering richer phenomenological descriptions.

Ensuring Data Accuracy and Credibility

Member check. Shortly after the interview was completed, the investigator mailed a brief letter thanking the individual for participating and reminding him or her of the next step in the research process, the member check (see Appendix F). Over the next 2-4 weeks, the primary investigator coded each interview transcript for emergent themes (see steps 1-6 of data analysis below). Once completed, a list of themes along with the corresponding verbatim responses was sent to each participant via e-mail. Each participant was asked to provide feedback about the themes generated from their interview in order to ensure that the investigator accurately captured what he or she meant to convey in describing their experience. All six participants responded affirmatively to the analysis and replied that the themes correctly captured what they meant to convey.

Second reader audit. IPA emphasizes the importance of having a second person audit portions of the analysis in order to enhance the validity of data interpretation (Smith & Osborn, 2008). After each transcript was individually analyzed by the primary investigator and had undergone the member check, the transcript was given to a second reader/coder. This second reader then coded each transcript for emergent themes according to the same process used by the investigator (see data analysis steps 1-7 below). After all of the transcripts were analyzed by this method, the primary investigator and second reader worked together to organize a final master list of themes for the entire data set (see Analysis for Superordinate Themes and Themes in Results section for more details). The second-reader audit was meant to identify and mitigate the effect of investigator biases on the interpretive process (Creswell, 1994).

Data Storage

All hard copies of documents were kept in a locked filing cabinet in a locked office, with only the principal investigator having access to the files. Furthermore, the informed consent and demographic questionnaire—the only documents containing participant names and other identifying information—were stored separately from all other participant data, such as interview tapes and transcripts. All other participant data were identified by code number only. A password-protected electronic file containing a master list of names and corresponding code numbers was created to ensure accurate data management. The computer's desktop required a separate password and the computer itself was stored in a secure location, thus providing two more layers of protection. The principal investigator was the only person with access to this computer and knowledge of the passwords.

Data Analysis

This study analyzed interview material by following the step-by-step idiographic approach to IPA transcript interpretation illustrated in Smith and Osborn (2008). The goal of the idiographic approach to data analysis was to understand the personal *meanings* embedded in participants' responses by engaging in a sustained interpretive process with the text. The following section describes this process:

1. The first participant's transcript was read and re-read several times by the principal investigator (PI) in order to gain maximum familiarity with the experiential description at hand.
2. After immersion in the text, the PI wrote down comments and observations in the left-hand margin that struck him as interesting, meaningful, or important. Smith and Osborn (2008) noted that there were no hard and fast rules governing this first step.

Comments served a variety of purposes including summarizing or paraphrasing what the individual said, amplifying content by making associative links, and noting similarities and differences (as well as contradictions) in material throughout the text. The writing process continued for the entirety of the first transcript.

3. The PI returned to the start of the first transcript and transformed the initial comments and observations into emergent themes, documenting theme titles in the right-hand margin. The goal of step 3 was to capture and convey the essential quality of what the participant said by choosing concise phrases (i.e., theme titles). The themes or phrases were theoretical abstractions, the origins of which could be directly linked to particular sections of actual text. The PI continued until the first transcript was complete, noting similar emergent themes occurring throughout the text and repeated theme titles, when appropriate.
4. The PI created an initial list of emergent themes in an Excel file, recording each theme title as it appeared chronologically in the first interview. Using Excel allowed the PI to sort by themes and facilitated recognition of patterns and connections in the data.
5. The PI reviewed this list of themes to see if there were similarities or connections between them. Some initial themes clustered together into superordinate themes, thus refining the meaning of what the participant said. Throughout the process, the PI re-checked the primary source material to be certain that his thematic interpretations directly related to what the participant said.
6. Next, the PI constructed a comprehensive, coherent table of themes in which the title of each superordinate theme was listed. Underneath each superordinate theme was a list of theme clusters that, taken as whole, represented the superordinate theme. Identifiers such

as key words and page numbers from the transcript were added in order to facilitate location of themes in the actual text. Finally, some themes were dropped at that time if, for instance, they were insufficiently supported by text material or seemed to be outliers in the emerging thematic structure.

7. Smith and Osborn (2008) offered two options for analyzing the remaining data. Option one was to use themes coded from the first transcript to orient the analysis of subsequent transcripts. Option two was to analyze the other transcripts from scratch, that is, without using the first transcript's themes to inform the process. This study employed the latter method in order to allow each interview to essentially speak for itself by reducing the chances of being unduly influenced by preconceived ideas during the interpretive process.
8. After all six transcripts were analyzed separately by the PI and auditor, the PI and auditor got together on two separate occasions to create a final master table of themes for the entire participant group by condensing the pooled data into a higher-order list of superordinate themes. Throughout the final part of the analysis, the PI and auditor prioritized themes according to their richness and meaningfulness while respecting theoretical convergences and divergences in the data. Once again, identifiers were used to ground thematic content in the actual text. Representative examples for each theme were included in Table 1.
9. The PI translated Table 1 into narrative form, at times using verbatim accounts from the transcripts to illustrate and highlight the particular theme. In this step, Smith and Osborn (2008) encouraged the writer to clearly distinguish between *interpretations* of the participant's words and the participant's actual words. The PI and auditor adhered to this

suggestion.

10. Finally, Smith and Osborn (2008) presented two options for presenting the results. The first was to divide the write-up into the traditional results and discussion sections and the second was to collapse the write-up into a single results and discussion section. This study employed the traditional write-up method (i.e., the first option).

Results

Superordinate Themes and Themes

A master list of 18 themes was constructed by noting similarities and overlap in thematic content within and between interview narratives. In order to be labelled a *theme,* material had to either appear in multiple participant narratives, or else had to stand out according to the material's saliency (e.g., Analyst is Drawn into a Spiritual Experience, A4). The principal investigator and auditor then clustered the 18 themes that emerged, according to the themes' shared characteristics, into six superordinate themes: CT has origins in analyst's wounds; CT triggers; manifestations of CT; CT effects; CT management; and contextual factors in analysis. These superordinate themes are presented in Table 1 (see Appendix G) along with the superordinate themes' corresponding themes and representative quotations from the interview narratives.

Participant examples. Before describing the present study's main thematic findings (see *Main Thematic Findings* below), two participant exemplars are discussed. Exemplars were included in order to highlight how CT phenomena tended to unfold over time and to convey a clearer, more integrated sense of how participants tended to experience, make sense of, and deal with CT. Exemplars were also included in order to provide a more cohesive framework for

understanding how to integrate clinical implications from this study into practice. One exemplar, Analyst 6, described a case of relatively good CT management/outcome and the other exemplar, Analyst 2, illustrated a case of poorer, or less effective, CT management/outcome.

Analyst 6. Analyst 6 was a participant who, over many years of working with the client, became increasingly conscious of the negative effects of CT on the analysis—a development which ultimately facilitated a positive outcome for both parties. Analyst 6 described experiencing an immediate, deeply unconscious CT originating from Analyst 6's long-standing father-complex and triggered by perceived similarities between the client and Analyst 6's father. CT manifested as Analyst 6 perceiving and acting toward the client as if the client was "stupid" (a perception Analyst 6 had about Analyst 6's father at the time). According to Analyst 6, the initial negative effects of CT were largely mitigated by the client's patience, intelligence, and willingness to do the analytic work. As time went on, Analyst 6 described having more loving and nurturing CT feelings for the client. These more positive CT feelings, coupled with Analyst 6's growing consciousness about the roots of CT—an awareness partly achieved by Analyst 6's self-described "personal work" on the father-complex—resulted in a strengthening of the analytic relationship. The deep analyst-client bond was marked by unconscious events such as client dreams that, as reported by Analyst 6, played a critical role in mutual healing and transformation.

Analyst 2. Analyst 2 described having never entirely come to terms with the CT over the course of analysis, thus limiting the client's progress. Analyst 2 reported having been triggered countertransferentially by the client's "negative mother" projections and the client's difficult interpersonal style, with CT manifesting as intense bodily sensations of oppressiveness and feelings of floating away from the client. Analyst 2 described the CT as originating not only

from the client's projected material, but also from cultural differences between Analyst 2 and the client (and the associated negative perceptions of self and other). As time went on, CT manifested as Analyst 2's feelings of devaluation, irritability, and worthlessness—with Analyst 2 describing (to Analyst 2's dismay) an overall feeling of being unable to fully help the client. Moreover, despite having had more positive/nurturing CT towards the client at times, and despite attempts to become more aware of and better cope with CT, Analyst 2 described a persistent inability to "like," and therefore bond, with the client. According to Analyst 2, this failure to fully connect with the client significantly hindered the analytic process and outcome. Finally, Analyst 2 surmised that if the client had decided to stay in analysis longer, than perhaps a stronger bond would have eventually developed (in part, because Analyst 2 came to a better understand the CT over time), thus improving client outcome.

Exemplars, comparisons and contrasts. The forgoing exemplars were similar to each other and to the remaining four cases in that CT was determined (at least, in part) by some kind of psychological wound in the analyst (e.g., Analyst 6's father-complex and Analyst 2's culturally-induced wounds). Furthermore, Analyst 6 and Analyst 2's CT manifested, in general, as a distancing from the client—a manifestation of CT described in all but one narrative (i.e., Analyst 4).

A main difference, of course, was that Analyst 6 was relatively more successful compared to Analyst 2 at dealing/coping with CT, thus contributing to a better outcome. Likewise, although Analysts 1 and 3 both described the negative effects of CT on analytic process at times (see below), Analyst 3 was ultimately more successful in managing CT (thus resulting in a better outcome) compared to Analyst 1, who was never able to successfully resolve the CT (thus resulting in a poorer outcome).

One important factor affecting these differential findings of CT management/outcome seemed to be different degrees of analyst-client bonding. Both Analysts 6 and 2 highlighted the significance of the therapeutic relationship on the analytic process, a theme that emerged from almost every other narrative. A notable difference, however, was Analyst 6's ability to fully bond with the client compared to Analyst 2's persistent failure to bond—despite the fact that Analyst's 6 and 2 both reported having had positive, nurturing CT feelings (also described by Analyst 5) towards their respective clients. One factor that may have affected the aforementioned differences in bonding was that Analyst 2's analysis with the client was much shorter than Analyst 6's analysis. Another factor may have been the influence of a transcendent power. Unlike Analyst 2, Analyst 6 described a transcendent power as having influenced the therapeutic relationship and eventual healing of both the client and Analyst 6—a theme also described by Analyst 5 (see below).

Main Thematic Findings

Below is a description of all superordinate themes and themes that the principal investigator and auditor identified, along with supportive examples from the interviews woven throughout the text. Certain words in quotations were italicized when the participant seemed to place emphasis on those words during the interview (e.g., by changes in volume, tone, and inflection when speaking).

Countertransference has Origins in Analyst's Wounds

Participants' CT was typically elicited when some sore spot or wound in the participant was triggered by some characteristic of the client or therapeutic situation. Regarding the former, all six participants explicitly described the participants' own conflicts, needs, and vulnerabilities, or personal wounds, as being a chief source of participants' CT. The stimulation of these

wounded parts, according to each participant, significantly determined the nature of participants' CT—the particular thoughts, feelings and images that were experienced. Two categories emerged from this superordinate theme: wounds rooted in personal history and wounds as complexes.

Wounds rooted in personal history. All six analysts described how the analysts' wounds derived from the analysts' recent personal histories—with five (all except Analyst 1) referencing a specific difficult experience in the analysts' adult lives such as a recent divorce (Analyst 3), a personal trauma (Analyst 5), and separating from a nurturing spiritual group (Analyst 4), to name a few.

Three of the analysts (3, 5, and 6) described the analysts' personal wounds as having originated even earlier in the analysts' personal histories. For example, expounding on Analyst 5's "sense of being violated" by the client, Analyst 5 drew a link to an earlier time, "it was extremely difficult for me in my *own* life, from a very early age…boundaries were *constantly* being violated."

Wounds as complexes. At certain times in the interview, four participants (Analysts 1, 2, 3 and 6) used the Jungian term *complex* when describing the nature of the analysts' particular wounds and discussing how these wounds shaped the CT. By definition, a complex consists of both personal and impersonal, or archetypal components (Samuels, 1985b). For example, Analyst 1 described Analyst 1 as once having a "terrible authority complex" and Analyst 3 described Analyst 3's personal struggles with a "mother complex."

Countertransference Triggers

All six analysts described attributes and behaviors of the client that touched upon or triggered the analysts' own wounds and ultimately led to a CT reaction. Three categories of

client qualities and behaviors that interacted with analysts' wounds to trigger CT were identified: client similarities; projections from client; and client's troublesome interactive style.

Client similarities. Analyst 3 described how Analyst 3's CT was triggered by similarities with the client's experiences, and Analyst 6 explained how the CT was stimulated by how similar the client was to Analyst 6's own father. In the first example, Analyst 3 and the client were both professionals trying to come to terms with a recent, painful divorce. At times, Analyst 3's insecurities about being a single parent were triggered by the client's expressions of anger and shame in session, feelings related to the client's struggles with being a single parent. In the second example, Analyst 6 described how the client's physical appearance and overall presentation reminded Analyst 6 (unconsciously at first) of Analyst 6's own father, someone whom Analyst 6 erroneously perceived as being "stupid" when Analyst 6 was younger. Analyst 6 explained, "I always thought my father was stupid, but I [eventually] learned differently through this client….[initially, the client] was my stupid father…it was [the client's] appearance and [the client's] mode of operation. It was slow and deliberate, *too* deliberate for me."

Projections from the client. Three participants (Analysts 2, 4 and 5) described situations in which the client's projections onto (or into) the analyst triggered a CT reaction. In these three cases, in addition to the triggering of the analysts' own wounds, analysts described how the CT was determined by whatever unconscious material was being projected by the client.

In one example, Analyst 2 characterized the CT in terms of feelings of "unworthiness" and "devaluation." Although, according to Analyst 2, Analyst 2's own personal complexes could indeed partly account for the feelings of devaluation, Analyst 2 explained how there was yet another important contributing factor to consider, that of the client's projections. Analyst 2 understood the CT, to a certain extent, as being a manifestation of the client's projection of the

"negative mother" onto Analyst2. Analyst 2 saw this projective process as being a kind of "induction," in which Analyst 2 essentially became the negative mother in order for the client to be able to work out the client's personal "mother issues" in analysis. As Analyst 2 explained, "it's like this reflection on [the client] around not being valued…where [the client] wasn't protected by [the client's] mother and wasn't valued by [the client's] mother…so then, *that's* [devaluation] what got projected onto me."

Client's troublesome interactive style. The triggering of CT by the challenging ways in which the client interacted with the analyst was identified as a common theme in three narratives (Analysts 1, 2, and 5). In every case, analysts understood these problematic modes of client relating to be both symptomatic of the client's borderline or narcissistic pathologies as well as indicative of the client's earlier difficult relationship patterns.

In one case, Analyst 1 described the client as exhibiting a number of troubling attitudes and behaviors that Analyst 1 characterized as being "manipulative," "provocative" and "blaming," and which triggered feelings of disgust. For example, Analyst 1 described the client as making unreasonable demands upon Analyst 1, in areas of personal attention, analytic fees, and insurance claims, preemptively creating what Analyst 1 called "no-go zones" (i.e., declaring certain relevant topics as off-limits for discussion), and establishing seemingly arbitrary contingencies about when the client would or would not communicate with Analyst 1.

Manifestations of Countertransference

This third superordinate theme comprises the ways in which CT presented in the analyst. All six participants described how CT manifested in session and three themes were identified as the main forms in which analysts' CT was expressed: analyst's full engagement with client is disrupted; analyst wishes to care for client; and the analyst is drawn into a spiritual experience.

These accounts of CT manifestation tended to have a kinesthetic quality, with analysts often describing an experience of being "pushed" or "pulled" away from or towards the client.

Analyst's full engagement with client is disrupted. Almost all participants (Analysts 1, 2, 3, 5 and 6) described CT experiences which manifested in such a way as to diminish the analysts' capacity to engage fully with clients or the analysts' ability to accurately assess the analytic situation. Analysts 2 and 5 described having CT reactions which were experienced as having part of themselves essentially taken or cast out of the analysis, thus creating a kind of emotional or psychological distance from the client's experience as well as from the analysts' own physical sensations. As Analyst 2 described, "I had a hard time just *feeling* my body 'cause it was kind of like *floating*…I wanted to leave my body…I felt like I just wanted to *not* be in the room." These CT experiences tended to hamper the analyst's ability to function optimally and were understood by the analyst as being, in part, a defensive reaction to having the analyst's wounds triggered.

Analyst 5 provided a compelling description of how the CT momentarily disrupted engagement with the client. After listening to the client describe a dream that included very private aspects of Analyst 5's personal life, Analyst 5 stated: "It was almost dissociative for me, to the extent that I did not hear much of the content of the dream that came after, than I became extremely frightened and extremely guarded." Elaborating, Analyst 5 said: "I was aware for at least ten minutes into the discussion about the dream that I was only fifty percent present and that part of me had really drifted into a protective, 'what the hell is this all about?' place."

Analyst wishes to care for client. The theme of the analyst wanting to care for the client in the CT was identified in three narratives (Analysts 2, 5, and 6). Overall, the analysts' CT was expressed as greater than usual feelings of empathy, connectedness, love, and acceptance

towards clients. Not only did these CT feelings go beyond the analysts' typical desire to care for the client, but all three analysts also remarked on the unusual strength of these feelings compared to experiences with other clients. For example, Analyst 5 described unusually strong in-session CT feelings that reverberated to a desire for deeper emotional intimacy with the client (feelings Analyst 5 never acted upon): "I remember one time specifically that went on for probably ten minutes where I was feeling very soft and very unchallenged…I wish I could have known [the client]. I wish we could have sat at my dining-room table and talked."

Analysts 2, 5 and 6 explicitly described the CT feelings as essentially being a kind of maternal impulse to care for the client. For example, Analyst 5 and Analyst 6, respectively, commented on the CT: "it's [CT] really maternal…it's about the softness of the mother" and "the other [CT reaction] was the mother thing where I was the mother who loved and accepted [the client], and I was probably the only person who did."

Analyst is drawn into spiritual experience. Analyst 4 spoke about having had a decidedly *spiritual* response to the client in which Analyst 4 felt like Analyst 4 was "floating" in the CT, or being taken out of Analyst 4's body into a spiritual state: "there's something in this [CT] experience that tends to take me out of the material world as if I were floating above it in some way." Analyst 4 compared the CT to the experience of falling in love and understood the CT reaction as having been "drawn into" the client's spiritual world, a phenomenon that also served to meet the spiritual needs of Analyst 4: "it renewed for me the importance of [the client's] world…the spiritual world, whatever you want to call it…so, I felt that was really a gift…it reopened [for me] that other world…that world of the spirit."

Countertransference Effects

All six analysts described the effects of CT on both client and analyst processes and

outcomes. These CT effects on analysis were grouped under the following four themes: negative effects on analytic process/outcome; strengthened or weakened the analyst-client bond; analyst gained confidence in handling CT; and mutual healing and transformation.

Negative effects on analytic process/outcome. Four participants described the adverse effects of unmanaged CT on the analytic process and outcome. Analysts 1, 2, 3 and 6 described how the CT contributed to a hindering or obstructing of the analytic process, largely through the negative effects of CT on the client-analyst relationship. Analysts 1 and 2 described the CT as limiting the analytic gains made by the client; both analysts believed that treatment was less beneficial for the client as it could have been due to the harmful effects of the CT.

In one case, Analyst 1 talked about how the CT prevented Analyst 1 from confronting the client's manipulative behavior (see also Client's Troublesome Interactive Style). Remarking on why Analyst 1 delayed, Analyst 1 said, "Well, I hate to be rejected so countertransferentially, I wouldn't want to perpetrate that on someone." According to Analyst 1, this delay in confrontation hindered the analytic process by allowing the client to simply get away with bad behavior and avoid doing the necessary analytic work. Moreover, Analyst 1's CT effectively fueled a behavior pattern wherein the client, as Analyst 1 put it, "didn't want to pull [the client's] own weight." By the time Analyst 1 figured out what was happening in the CT (i.e., letting the analysis go on too long), the CT-based interventions (i.e., confronting the client about the client's *bad* behavior) were ineffectual, or *too little, too late*, in terms of helping the client get better. Pondering what may have been done differently in this case, Analyst 1 remarked, "I would have held [the client's] feet to the fire much earlier and not have been so sympathetic as I was."

Strengthened or weakened the analyst-client bond. The theme of transference-countertransference dynamics either strengthening or weakening the bond between

analyst and client was found in five narratives (Analysts 2, 3, 4, 5 and 6).

Four analysts (Analysts 3, 4, 5 and 6) described shared positive feelings towards the client that strengthened the analyst-client bond and facilitated the analytic work. The most salient of these experiences was found in Analyst's 6's description of the deep bond shared with the client: "We really loved each other. A very deep, deep love…there was a connection on a deep soul-level." Analyst 6 understood this strong bond to have developed partially from a maternal dynamic in the transference where Analyst 6 was the "loving mother" who cared for the client or "child" (see Analyst Wishes to Care for Client) and partially from the fact that Analyst 6 and the client were working together towards the same personal goal, the healing of the father-complex (see Mutual Healing and Transformation).

Analysts 4, 5 and 6 highlighted client behaviors and traits—such as the client's intelligence, sense of humor, and enthusiasm for doing analytic work—that helped strengthen the analytic bond. The basic idea expressed by all three was that these client factors helped the analyst and client stay together through periods of negative CT, thus facilitating the analysis. For example, Analyst 6 described the client as enduring periods of CT acting out or times when Analyst 6 missed something important because Analyst 6 was blinded by the CT. Analyst 6 stated, "I felt impressed that [the client] stayed with me, that [the client] did not say, 'fuck you,' you missed the ball on this one…[the client] was the more *enduring*, the more *patient* of the two of us."

In contrast, Analyst 2 described having experienced mutual negative feelings that resulted in a persistent failure to develop a bond. Analyst 2's basic dislike of and irritability toward the client prohibited the formation of a good bond and thus hampered the analysis—as Analyst 2 stated, "I think it was part of the countertransference, like I just *could not* like [the client]. I

couldn't get beyond that part of place where *I* was stuck in the countertransference."

Analyst 2 understood Analyst 2's feelings of dislike for the client to be informed by a number of sources, including contributions from Analyst 2's own wounds, which presented countertransferentially as Analyst 2's refusal to be drawn into a relationship where Analyst 2 was made to feel subservient to the client. Analyst 2 also understood Analyst 2's dislike of the client to be part of the "negative mother transference" in which the client fails to bond with the analyst just as the client failed to bond with the client's own alcoholic mother (see Projections from the Client). As Analyst 2 explained, "in the countertransference, I would be irritated with [the client] and didn't want to bond with [the client]. I knew that that was part of the induction, the alcoholic mother is not going to bond with you."

Analyst gained confidence in handling countertransference. In four interview narratives (Analysts 2, 3, 5 and 6), analysts described having developed confidence in the overall ability to deal with CT, in a large part because of the analysts' CT experiences with clients.

For example, Analyst 3 reported that working with the client taught Analyst 3 to be more secure in Analyst 3's ability to simply watch the analytic process unfold without getting triggered countertransferentially. Analyst 3 attributed this enhanced security to having had matured psychologically, a process Analyst 3 said was helped along through work with the client. At the same time, however, Analyst 3 noted that it was not *only* the client under discussion that helped Analyst 3 grow, but also Analyst 3's experiences with others. As Analyst 3 stated, "I think it's always hard to tease out exactly what a *particular* client [did to change me]…a lot of the issues that I'm working on might be triggered by [the client], but [also by] other people as well."

In another example, Analyst 2 discussed how Analyst 2's experiences with the client

helped Analyst 2 become more assured of Analyst 2's ability to modulate the CT. Analyst 2 stated, "I'm not so afraid of it [CT]. I'm not so afraid of *myself* in the countertransference. I'm not so afraid that I'm gonna get 'full-blown' or 'overblown,' or something's gonna come up that's just *totally* unmanageable."

Mutual healing and transformation. Analysts 5 and 6 described both themselves and the client as having been "healed" and "transformed" as a result of the analytic work with the client, particularly in regards to working through transference-countertransference issues. Although Analysts 5 and 6 acknowledged that the personal transformations were shaped by many factors, such as work with other clients, each analyst recognized the essential, transformative effects of the CT with the client under discussion.

The main transformation motif expressed by Analyst 6 was that together Analyst 6 and the client, over many years, managed to get free from the destructive grip of Analyst 6's and the client's respective father-complexes. By doing so, Analyst 6 noted that the client became happier and more productive in the client's work-life and embarked upon a healthier second marriage. Moreover, Analyst 6 described Analyst 6 near the end of the analysis as being "healed," becoming "more patient" with others, and being "energized" by the work with the client —changes for which Analyst 6 expressed gratitude: "I had the opportunity to become something different because of this [analysis]…[I was] *privileged* to go through it [analysis] with [the client]."

Analyst 5 also expressed gratitude and appreciation for the transformative experience with the client and recognized the uniquely meaningful impact of the client on Analyst 5's life: "fewer clients have gotten *in* more *personally* or affected me more *personally* than [this client]." However, Analyst 5 chose to not discuss Analyst 5's own healing in depth, but instead focused

on the client's "transformation," as Analyst 5 described it, noting the client's improvements in regulating affect, maintaining personal boundaries, and being more comfortable with sexual orientation.

Countertransference Management

All participants spoke about analysts' efforts to handle or cope with CT in order to facilitate analysis. Within this superordinate theme, the principal investigator and auditor found three common themes: in-session modulation with awareness and understanding; analyst works on personal self throughout analysis; and modifying/adapting the analytic frame.

In-session modulation with awareness and understanding. Five participants (Analysts 2, 3, 4, 5 and 6) talked about analysts' efforts to modulate the negative effects of CT by becoming more aware of what was going on in the analyst during the analytic hour. These five participants described how analysts were at times able to facilitate analysis or curtail a countertransferential acting-out by focusing more attention on the analysts' own internal processes in-session while simultaneously reflecting on *where* the analysts' reactions were coming from and *why* the analysts were thinking or feeling a certain way at the moment.

In one example, Analyst 5 described attending to the "tightening of the viscera" in-session (a common CT response for Analyst 5) while considering why Analyst 5's body was reacting in such a way. When Analyst 5 concluded that the CT was largely a response to a felt impingement on Analyst 5's personal space (e.g., when the client asked too many questions about Analyst 5's life), Analyst 5 was then able to make deliberate efforts to relax and stay open to the client. In another example, Analyst 2 described the process by which Analyst 2 prevented CT behavior by sitting with and attending to bodily sensations.

In sitting, things came up in [my] body. I just made a note of them and said [to myself]

> 'Oh, I'm feeling this in my body,' and then there might be an image to it, like, 'Oh, I'm feeling this itching here,' 'Oh, my attention's gone there,' 'What is [the client] saying?' How is that making me uncomfortable, what [the client's] saying?' 'Well, is it making me uncomfortable?'…'Something's happening.'

Analyst works on personal self throughout analysis. Three participants (Analysts 3, 5 and 6) discussed how the process of working on the analysts' own issues over the course of analysis helped the analysts modulate CT. By healing the analysts' own wounds in parallel with working with the client, these analysts were better able to cope with troublesome reactions stemming from the stimulation of these analysts' wounds, thus mitigating the negative effects of unmanaged CT on the analysis.

Two analysts (3 and 6) said that while not in a personal analysis or therapy during the period of working with the client, Analysts 3 and 6 did engage in continuous self-work outside the consulting room. For example, Analyst 6 worked on Analyst 6's own dreams as part of the healing of Analyst 6's father-complex—the main source of Analyst 6's CT. Both analysts noted that although the goal of the self-work was not necessarily to improve Analyst 3 and 6's ability to work in the CT with the client (Analysts 3 and 6 saw the analysts' own healing process as more organically tied up with the client's healing), Analyst 3 and 6's self-work indirectly, yet ultimately, helped serve this purpose.

Modifying/adapting the analytic frame. Two participant narratives (Analysts 1 and 5) contained descriptions of the analyst changing the analytic frame to try to better cope with CT. Analyst 5 provided the most explicit account of modulating the CT by relaxing the boundaries of the analytic frame. In a nutshell, Analyst 5 eased the CT tension at times by allowing the client to have more session time and by granting the client a glimpse into Analyst 5's personal life:

"instead of tightening my viscera [CT] to the question, 'Where are you going?' 'When are you coming back?' - to just relax into saying where I was going and saying when I was coming back."

In contrast, Analyst 1 spoke about efforts to manage the CT by essentially fortifying the analytic frame. In an attempt to extricate from a CT enactment in which Analyst 1 was, as Analyst 1 put it, "too sympathetic" in response to the client's demanding behavior, Analyst 1 finally confronted the client about the client's evading personal responsibility and expecting too much of the analyst. Analyst 1 reported, "I said my countertransference out loud, I said, 'I feel like I'm being pushed in a corner here,' 'I feel like you're [the client] wanting to get something for nothing *here* [in analysis] also, a free ride.'"

Contextual Factors in Analysis

All narratives contained descriptions of background, or contextual elements that influenced the countertransference-dynamic and helped shape the analytic context or situation. These contextual factors were grouped into three categories: time factors or considerations, the collective unconscious or some other transcendent power, and cultural factors.

Time factors or considerations. The influence of time on the analytic process, such as in the length, frequency, and pace of the analysis, was identified as a common contextual theme emerging in four interview narratives (Analysts 1, 2, 5 and 6). For example, Analyst 5 acknowledged that the length and frequency of the analysis (i.e., about 4 years, with 3 to 4 sessions per week) were not only part of what made this case so taxing, but the length and frequency were also critical factors in achieving what Analyst 5 described as a "transformation" in Analyst 5 and the client. Similarly, Analyst 6 emphasized that transformative healing was able to come about in Analyst 6 and the client because the analysis lasted for several decades. The

basic idea expressed by both Analysts 5 and 6 was that the analyst and client stayed with each other long enough, through many difficult periods, to allow the work that needed to be done (in the analyst and client), to get done. As Analyst 5 put it, "I mean, parts of the analyst I am today, many years later, is because [the client] stayed with me and I stayed with [the client]." In contrast, Analyst 2 believed that the client dropped out of analysis too soon to be able to meaningfully address the client's most salient issues: "to get an understanding of the negative mother-complex, [the client] needed more time [but the client] didn't stay. [The client] came to therapy wanting to be fixed, [but] it takes time to *build* relationships."

Time also emerged as a contextual factor in another way. Three participants (Analysts 1, 2 and 6) described situations where the client chose to leave the analysis for a period of time, and then return to continue with the work. During these breaks in analysis, Analysts 2 and 6 described the client as having gained some important perspective or understanding of themselves or achieved some mastery of a problem. For example, Analyst 6's client was diagnosed with ADHD by another therapist after temporarily leaving analysis. Analyst 6 saw this ADHD diagnosis as a defining moment in the work because the diagnosis challenged Analyst 6's CT-based perception of the client as being "stupid."

The unconscious or some other transcendent power. Descriptions of how the unconscious or some other transcendent force influenced the analysis were identified in four narratives (Analysts 2, 4, 5 and 6). For example, Analysts 2, 5 and 6 gave detailed examples of the clients' dreams and discussed how these dreams were important to the analytic process. Analyst 2 reported frequently using the client's dreams to get a better understanding of what was *really* going on with the client, and how the client actually felt about important people in the client's life, including the analyst. After reporting on the client's dream, Analyst 2 stated: "This

is clearly a 'mother-complex' dream...and about *us* and the analysis. So, [the client] feels horrified, [the client's] frightened, and [the client's] repulsed. And I think [the client] felt *all* of those things in working with me." Moreover, Analyst 6 described how a major client dream containing archetypal and religious imagery of healing ultimately proved to be the "key" to freeing both the client and Analyst 6 from the destructiveness of each one's personal father complex.

Analyst 5 provided a number of striking examples of what Analyst 5 called "coincidences" or "overlaps" between client and analyst that, Analyst 5 admitted, were sometimes "eerie" or "scary" and that Analyst 5 could not account for with logical explanations. These overlaps or parallels between Analyst 5 and the client occurred unconsciously (e.g., the client's dreams replicating private events of Analyst 5's life) and consciously (e.g., the client's trauma occurred temporally close to what Analyst 5 called Analyst 5's own, personal "life-changing trauma"). Analyst 5 described how these coincidences at first raised existential questions about the meaning of it all, but eventually, Analyst 5 understood these coincidences as being part of a "*very* deep karmic connection" between Analyst 5 and this particular client where, in essence, some kind of larger force brought Analyst 5 and this client together for the purpose of "something that we were *working out together, that only we could do for each other*."

Cultural factors. The theme of cultural, social, or gender factors influencing the analysis was identified in four interview narratives (Analysts 1, 2, 3 and 6). For example, Analyst 2 noted that potent cultural-historical differences between client and analyst contributed to CT feelings of worthlessness, being "on guard" and "on edge" with the client in session, and a sometimes exaggerated perception of the client as acting superior towards Analyst 2. In the end, Analyst 2 acknowledged that these cultural differences were part of the wedge that kept Analyst 2 and the

client at a distance from each other and thwarted analytic progress.

In other narratives, gender/sexual topics and concerns were identified as being important to the analytic context. One analyst spoke about the challenges of working the client during the feminist movement, a time when, according to the analyst, "some believed [women] should never work with a male therapist…there was still a part of that period that led women off and to almost do a counter-dependent or to…not to take anything on authority, but to challenge everything."

The analyst discussed how the backdrop of feminism aggravated an already tense analytic situation stemming from recent relationship difficulties experienced by both parties. According to the analyst, feminist influences thus made it even harder for trust to develop in the analytic relationship and for each person to accurately perceive and understand the other. For instance, the analyst described how the analyst had to be vigilant in the CT to not interpret the client's general anger about male-dominance in society personally. Part of being vigilant for the analyst meant seeing the CT from a broader perspective: "to understand it [CT] in the context of the larger struggle today, what men and women are dealing with, and the attempt to change the old balance of power and come to a new one."

Another analyst's interview responses chronicled two men engaging in a lengthy period of analytic work together. In several different ways, the analyst described an underlying motif of both individuals *becoming their own man* as analysis progressed. According to the analyst, this *becoming one's own man* entailed a "breaking free" or psychological separation from the father while developing trust in one's own personal autonomy and power. A similar idea emerged from another analyst's narrative as the analyst described personal struggles with relationship issues with women: "Part of the complex I was working through [was]…the confidence in *my own*

sense of security, that I didn't have to be afraid of…this power (that is, the analyst's own inner power and female power)…but welcome it."

Discussion

The discussion section begins by considering the most salient emergent themes of this study—those endorsed by five or six participants—in relation to the existing CT and Jungian literature: CT originates from analysts' wounds; CT manifests as analysts disengaging from clients; and CT is modulated with analysts' awareness and understanding. For each of these main findings, interrelated results from this study when applicable will be discussed, as well as some personal reflections on the findings. Next, the impact of CT on the nature of the therapeutic relationship will be discussed as well as temporal, cultural, and spiritual contextual factors that were found to influence the analytic process. The possible impact of personal biases and reactions to participants on the results will then be considered. Finally, the limitations of this study, clinical implications, and directions for future research will be discussed.

Connections between Study Results and Extant Literature

Overall, the findings from this study corresponded with the five key elements in Gelso and Hayes' (2007) evidence-based conception of CT (Origins, Triggers, Manifestations, Effects, and Management). Moreover, results from this study were consistent with Gelso and Hayes (2007) CT interaction hypothesis, which posits that CT is best understood by considering the *interaction* between therapist and client factors—for example the relationship between analysts' wounds and clients' triggers—rather than any one CT element in isolation. Overall then, this study supports the transtheoretical nature of Gelso and Haye's (2007) integrative model of CT and provides a common, relationally-centered ground for advancing discussions between Jungians and non-Jungians about analytic practice and CT phenomena.

Countertransference originates from analysts' wounds. All participants described the analysts' own wounds as an important source of CT, consistent with empirical research showing that CT tends to originate from therapists' conflicts, needs, and vulnerabilities (Baehr, 2005; Dieckmann, 1974, 1976; Hayes et al., 1998; Rosenberger & Hayes, 2002b). This finding also provides some much-needed empirical support for contemporary Jungian writings on the wounded healer in analysis (e.g., Merchant, 2012; Samuels, 2006; Sedgwick, 2001). In addition, the finding that all participants traced the origins of their wounds to their personal experiences, sometimes childhood experiences, is consistent with research pointing to the developmental nature of therapists' wounds (Baehr, 2005; Gelso & Hayes, 2007; Hayes et al., 1998).

It is perhaps not surprising that participants' psychological wounds emerged as a main determinant of CT, given this study's basic reliance on a more integrative definition of CT—one that emphasized the role of analysts' conflicts and vulnerabilities in CT formation—as well as this study's requirement that CT descriptions had to have been (at least partly) rooted in the analysts' own psychology. That said, however, participants as a whole indeed chose to emphasize the significance of their wounds in their CT descriptions. In other words, analysts' wounds *mattered* in their experiences of CT. The only partial exceptions were the times when participants described CT that analysts felt was influenced more by client material rather than the analysts' own psychological wounds (see Results, Projections from Client), which will be addressed below under Triggers.

Finally, it was not surprising that most participants used the Jungian term *complex* to describe analysts' wounds. According to Jungian definitions, a complex is thought to contain an impersonal, archetypal core that powerfully affects its possessor in some way (Samuels, 1985b). However, CT descriptions did not seem to vary based on the particular labels analysts gave the

wounds. Rather, participants tended to stress analysts having been caught up (at times, quite unknowingly/unconsciously) in analysts' own strong emotions or behavioral patterns that, when left unmanaged or uncontrolled, affected the analysis in some negative way. One of the most striking examples was that of Analyst 6's father-complex "poisoning" (Analyst's 6's language) the analysis to the point where Analyst 6 was unable to see the truth about the client having ADHD. Analyst 6's description is consistent with definitions of an illusory (Fordham, 1957, 1960) or neurotic CT (Racker, 1968). Illusory or neurotic types of CT are defined primarily by the analyst projecting his/her own unresolved conflicts onto the client, thus clouding the analyst's ability to perceive and understand what is really going on with the client.

Triggers. This study reinforced the notion that it is only meaningful to consider CT triggers within the context of how these triggers interact with the analysts' wounds and vulnerabilities (Gelso & Hayes, 2007; Gelso et al., 1995; Hayes & Gelso, 1993). For example, Analyst 6 described how the client's physical characteristics triggered Analyst 6's feelings about Analyst 6's own father, a person with whom the analyst had unresolved conflicts. Analyst 6's example fits into the broader notion that CT tends to get triggered when the analyst's unresolved conflicts coincide with similar conflicts in the client, a theme discussed but never empirically studied in the Jungian literature (Sedgwick, 2001; Steinberg, 1990).

At times, CT was triggered by the client's typical interactional style, leading to the kinds of transactional patterns described by interpersonal theory and research (Kiesler, 1996). In other words, analysts were frequently hooked into a maladaptive cycle with the client and then had to wrestle with difficult feelings and behaviors. This finding may serve as useful common ground between Jungian analysts and more interpersonal or relationally-oriented psychotherapists.

Those participants who used the term projective identification in their description of the

CT process seemed to de-emphasize (but not completely discount) the contribution of analysts' own wounds to CT development and highlight the unconscious quality of these "projections-from-client" triggers compared to the other, more overt triggers described in this study (e.g., clients' appearance, mannerisms, and interactive style). This latter point represents a step towards elucidating more covert triggers, a topic oft mentioned in the CT literature, but never rigorously examined (Gelso & Hayes, 2007). The finding that CT was highly influenced by unconscious material from the client may provide support for different types of syntonic CT put forth in the Jungian literature, namely Samuels' (1985a) *reflective* CT and *embodied* CT. For example, Analyst 5—in referring to Analyst 5's ability to pick up on the client's underlying sadness by attending to Analyst 5's own discordant feelings of sadness—was perhaps describing a reflective CT, that is, a CT reaction stemming largely from the client's current, yet unconscious, internal mood state. Analyst 2, on the other hand, described what seemed like an embodied CT, or CT reaction often experienced bodily in the analyst and caused by the client's projection of a long-standing inner object. Analyst 2's deeply felt bodily experience of "oppressiveness" and "unworthiness" in the CT was partially caused by Analyst2 having picked up on the client's experience of the client's devaluing, narcissistic mother.

Countertransference manifests as analyst disengagement. Participants' CT often manifested as some sort of disconnection from the client. This finding is consistent with several studies showing that the most common manifestation of CT is the analyst avoiding or distancing himself/herself from the client (Gelso & Hayes, 2007; Hayes et al., 1998; Hill et al., 1996). In contrast to the mainstream research, however, manifestations of CT in this study seemed to have a more dramatic, emotionally-charged, whole-body feel—for example, a feeling of floating away from the client or being cast out of analysis, as opposed to what may be more commonplace

experiences like avoiding a client's painful affect or ignoring a patient's verbalization (Hayes et al., 1998). For example, as Analyst 4 described, "there's something in this [CT] experience that tends to take *me*, in this case, out of the material world as if I were floating above it in some way."

Although Jungian literature typically warns of the tendency for analysts to over-identify with clients (Machtiger, 1995; Perry, 2008; Samuels, 2006; Steinberg, 1990), the participants in the present study erred in the direction of underinvolvement when caught in the CT. One explanation for this may be that analysts' CT was essentially a defense against getting too psychologically close to the client. In fact, even analysts who described having had a strong CT desire to get closer to and care for the client—what the mainstream CT literature might call *positive CT* (Hayes et al., 1998; Hill et al., 1996; Gelso et al., 1999)—still seemingly resisted acting on that urge. This explanation is consistent with research warning of the potential deleterious effects of positively valenced CT or *empathy gone too far* (i.e., being too understanding, too flexible, or overprotective; Gelso & Hayes, 2007), as well as studies showing that empathy helps analysts modulate or manage their CT feelings (Baehr, 2005; Hayes et al., 1997; Peabody & Gelso, 1982).

Although Analyst 4's description of CT seemed to stand out for its numinous or spiritual nature (hence Analyst 4's separate category under CT manifestations), Analyst 4's CT description also seemed to be consistent with the theme of analysts maintaining appropriate distance from the client. Analyst 4's CT, which Analyst 4 likened to the experience of "falling in love," had a definite feel of Analyst 4 having *gotten too close*, that is, having become over-identified with the client. Analyst 4 stressed the importance of having to stop from getting too caught up in the spiritual (although Analyst 4 admitted that Analyst 4 could have easily gone

further into the spiritual because the experience fulfilled Analyst 4's needs), lest Analyst 4 be rendered unable to treat the client, a client who needed help with problems in daily living. In Analyst 4's words: "I had to keep resisting that [pull towards spiritual]. I had to entertain it, because that's where [the client] and I were communicating, but I also had to resist it so that I could stay rooted in the analysis."

Countertransference is managed with attention and understanding. Analysts typically tried to manage the CT through increased awareness moment-to-moment during sessions, while at the same time trying to understand the causes of this CT. This finding suggests a possible link to research showing the therapist's self-insight or awareness is an effective CT management tool when the analyst has a sound conceptual framework from which to make sense of his/her CT (Latts & Gelso, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987). Indeed, analysts in this study emphasized the value of combining awareness with understanding in order to keep CT in check, and, it could be assumed, also made use of the Jungian framework in that reflection process. However, interview narratives generally lacked more in-depth explanations of how these two factors of awareness and understanding actually worked together to modulate CT, thus limiting further interpretation.

Other methods of managing countertransference. Two analysts described efforts to alter the analytic frame, in part to prevent CT from interfering with the analysis. This finding intersects with Lang's (1982) and Goodheart's (1984) ideas about CT and the analytic frame. Goodheart proposed that therapists, in an unconscious attempt to relieve the therapist's own CT anxiety, sometimes unknowingly change the frame (e.g., extend time, decrease fees, see client on off-hours), a behavior that, in the end, only hurts the analysis (e.g., by enabling the client). Therefore, therapists' must *hold the frame* (e.g., stick to session end times, keep fees the same) in

order to adhere to the analytic work at hand. Indeed, Analyst 1, whose CT caused Analyst 1 to be overly-sympathetic toward his client (e.g., agreeing to stay at a lesser fee, tolerating client's feigning illness) admitted that the work suffered from not having held steadfast to the analytic frame.

Analyst 5 also admitted to having tried to change the frame, for example by attempting to fire the client, during times when Analyst 5 was unconsciously caught-up in the CT. Analyst 5 first tried to temper this countertransferential acting-out by sticking closely to what Analyst 5 said Analyst 5 had always been taught—to *never* modify the analytic frame. Interestingly, however, Analyst 5 (contrary to Goodheart-Langs) eventually learned the value of sometimes being flexible around the frame, in this case by revealing a little personal information and extending session times a bit. In doing so, Analyst 5 relieved some of the underlying tension between the analyst and the client, which helped facilitate the analysis.

The finding that analysts' self-care helped analysts to better manage the CT is consistent with similar findings from research on the therapeutic process (Baehr, 2005; Hayes et al., 1991; Van Wagoner et al., 1991). However, given the emphasis on training analysis for Jungian analysts (Casement, 2010; Sherwood, 2010) as well as Catlin's (2006) finding that analysts stressed the importance of personal analysis, it was fairly surprising that participants did not focus more specifically on how analysts' own therapy or analysis, as part of analysts' self-care regiment, facilitated CT management. Perhaps participants chose to not open up about this delicate topic, or perhaps personal analysis was actually not as important for CT management as expected. Another explanation may be that participants focused on more proximal or current factors in managing CT, rather than more distal CT management factors such as personal therapy.

Countertransference effects on process/outcome. Several participants in this study described times when the analyst's unmanaged CT had deleterious effects on the analytic process. In such cases, analysts' difficulties in controlling CT seemed to result in some kind of break or distancing in the analytic bond, which then hampered the analysis in some way (e.g., by slowing it down). Those analysts who never really got a handle on the CT (e.g., Analyst 2), or did so too late (e.g., Analyst 1), were not only unable to establish a good working relationship with the client compared to the other four analysts, but also reported the worst outcomes. These results are consistent with research suggesting that a good therapeutic alliance functions as a critical buffer or mediator during difficult periods in analysis (Binder & Strupp, 1997; Bordin, 1994; Henry & Strupp, 1994; Horvath, 1995 as cited in Safran & Muran, 2000). As a whole, these findings are consistent with the Jungian outcome research (Keller et al., 2002; Mattanza et al., 2004; Rubin & Powers, 2005) and CT management findings (Hayes et al., 2011).

Positive client characteristics. Interestingly, some analysts extolled the client's positive traits—especially the client's intelligence and insight—as having played a vital role in essentially keeping the analysis alive and moving forward during difficult periods in the transference. This finding echoes Catlin's (2006) findings, which cited client intelligence and ego-strength as necessary for the client being able to do the analytic work. This finding also further highlights the mutual nature of the therapeutic relationship by showing that the client is sometimes responsible for helping see the analysis through periods in the analytic work.

Countertransference impacts the therapeutic relationship. Similar to Catlin's (2006) study of Jungian analysis, analysts in the current study tended to view the analyst-client bond or therapeutic relationship as an important component of the analytic process. Participants' vivid descriptions of the nature of the analyst's connection with the client, and how, for better or

worse, transference-countertransference dynamics influenced the analyst-client connection, thus provide a small empirical base for the extensive Jungian writings dating back to Jung on the healing nature of the therapeutic relationship (Knox, 2010; Wiener, 2009) and fits with decades of findings about the importance of the therapeutic alliance across modalities (see Safran & Muran, 2000 for overview).

Contextual factors in analysis. Transference-countertransference phenomena were also influenced by the broader temporal, cultural, historical and spiritual contexts or systems in which the analysis was embedded. These contextual factors can be generally thought of as *third factors*, or dimensions of the human experience that extend beyond the confines of the consulting room and continue to exert influence in-session (Wachtel, 2008).

Time. For some participants in this study, especially Analysts 5 and 6, a lengthier analysis with the individual client discussed generally meant the facilitation of deeper psychological change (for both parties). Analysts were rather vague, however, in explanations of *why* a lengthier analysis led to greater change and what role CT played in the change process. Some evidence suggested that client and analysts had to go through a series of CT flare-ups and resolutions, with the aid of a solid therapeutic relationship, in order to get to a place of deeper healing. Furthermore, even those analysts who described the benefits of a long analysis also remarked on the value of breaks in the analysis, or periods when the client left treatment (sometimes in an aggrieved manner) and then returned—usually in better shape than when the client left. There was a sense that client and analyst both benefited from these breaks, at least in part, by having gotten some temporary relief and distance from mounting tension in the transference-countertransference field, and were able to gain a new perspective during the time off from analysis. Perhaps a punctuated analysis is an effective CT management strategy?

Cultural. At different times, Jungians have been criticized for being ahistorical or indifferent to modern cultural and developmental perspectives while overly-emphasizing the archetypal dimension—a viewpoint challenged by the work of more recent post-Jungian theorists (Samuels, 2008). Interestingly, the current study found some evidence suggesting that Jungian analysts are indeed acknowledging the significance of cultural factors in shaping the CT, affecting the therapeutic relationship, and impacting the analytic work as a whole.

In one case, Analyst 2 admitted that the CT was to some degree determined by ingrained, sometimes distorted, often negative, and partly experience-based ideas about members of a different cultural group than Analyst 2's own group, and of which the client was a member. This description fits with what Gelso and Mohr (2001) would call *cultural countertransference* or *culturally reinforced countertransference.* Consideration of cultural CT is a relatively new development in the CT literature, in keeping with overall trends attending to cultural factors in psychotherapy (Gelso & Hayes, 2007). Presumably, this trend has extended to Jungians in thinking about cultural influences on CT (e.g., Singer and Kaplinsky, 2010).

Spiritual. Serious consideration of the numinous or transcendent is considered by many to be the *sine qua non* of Jungian analysis, the defining feature that sets Jungian analysis apart from other forms of analysis and psychotherapy (Stein, 2006b). Therefore, it was not surprising to find some participants describing spiritual or transpersonal elements as being important to the analytic work.

Although analysts tended to be somewhat vague in descriptions of the spiritual—in part, because the analysts admitted to not having a firm explanation for these extraordinary occurrences—a common theme did emerge, particularly among Analysts 5 and 6. The unconscious, as manifested in dreams and CT experiences, seemed to illuminate the specialness

of the analyst-client relationship and create a sense in the analyst of somehow having been brought together *with this particular client* so that both could go on a journey of mutual healing. Indeed, Analysts 5 and 6 discussed having undergone a personal healing transformation largely because of the Analyst 5 and 6's work with the individual client—an idea which gets at the heart of Jungian theory and analysis (Sedgwick, 2001) but is rarely encountered from an experiential point of view.

Although participants tended not to rely on Jungian jargon (except in attempts to educate the interviewer), it would be easy to overlay Jungian concepts that seem relevant here. For example, some might see the Self as the transcendent power in the examples of Analysts 5 and 6, guiding the client and the analyst towards individuation or, perhaps, interpret the amazing coincidences (i.e., the client replicating private aspects of Analyst 5's life in the client's dreams) as indicative of synchronistic processes at work.

Personal Biases and Reflections

According to IPA methodology, researchers are expected to continuously attend to personal biases and attempt to minimize the impact of these biases on data gathering and interpretation (Smith & Osborn, 2003). Working with another colleague(s), in this case a second reader/coder or auditor, is thought to further curtail the effects of investigator bias.

At the start of the study, it is fair to say that I was indeed fascinated by Jungian thought and, as such, had difficulty considering other viewpoints. One of the reasons for this bias had to do with my (generally positive) past work with a Jungian-informed therapist. Thankfully, with the help of my advisor and others, along with facing some personal struggles during the writing process, my perspective began to open up and has now shifted to a more integrative position where I try to see the positive and negative aspects of all psychotherapy models, including

Jungian. This position was certainly reinforced after I conducted the interviews. Overall, analysts' ways of thinking and working were less constrained and guided by Jungian theory than I had expected.

I am confident that I was able to keep my biases from unduly influencing the findings—a self-assessment supported by my second reader. The few expressions of bias that seemed to emerge were related to my pre-conceived notions about the importance of personal therapy for CT management and the primacy of dream work in Jungian analysis. In one case, I unknowingly tried to sway the conversation towards analysts acknowledging the role of their own analysis in being able to better manage their CT. I backed off from this line of inquiry when I sensed resistance from the participant (e.g., more pauses, faltering speech) and realized what responses I had, in fact, been encouraging. In two cases, I got sidetracked by my wanting to hear more about the details of clients' dreams (a topic analysts seemed quite eager to expand upon). When I realized the participant was veering too far afield from the primary topic at hand (CT), I redirected the interview back to the question under discussion.

Finally, in terms of the interviews themselves, I underestimated how difficult it would be to delve deeply into analysts' CT experiences. As with any interview process, I found it quite challenging to work with participants' resistance and to strike a balance between *pushing too hard* versus *not pushing enough* in order to obtain a rich dataset. Some of this uncertainty indeed stemmed from my own CT reactions to certain participants (and possibly the participant's CT to me). In fact, it could perhaps be concluded that the *dance* of the interview process mirrored, in some ways, the analyst-client *dance* reported by the analysts and in the CT literature in general. In both, the question of distance comes up—how close is too close? And, how far is too far? And, what factors must we consider to strike the right balance?

Study Limitations

There are several limitations to the current study. The small sample size certainly limits the generalizability of the findings. Although IPA methodologies and qualitative research in general are not concerned with generalizing results (Smith & Osborn, 2008), it is still important to note that this study's findings may not be representative of the larger population of Jungian analysts.

Another limitation has to do with the heterogeneity of the sample. Although all participants were certified Jungian analysts, the analysts varied on a number of dimensions that may have perhaps influenced how analysts conceptualize and work with CT in daily practice. For example, analysts received their analytic training at a variety of Jungian institutes across the United States, with one analyst having been trained in Zurich, Switzerland. In addition, participants cited a wide-range of different theoretical, spiritual, and psychotherapy models as having influenced analysts' analytic practice over the years. Furthermore, analysts reported having been at different stages in analytic training and professional career when analysts treated the client under discussion. Based on this variability, a legitimate concern can be raised about what "Jungian analysis" really means in this study. Are analysts talking about the same (or at least similar) process when analysts report having engaged in Jungian analysis with the client?

Other limitations of this study include the fact that analysts expressed different views on what analysts considered to be the central defining features of CT. Although analysts agreed in a general way that CT is defined as *something in the analyst* getting triggered by *something in (or about) the client*, each participant emphasized certain aspects of the CT that analysts felt were important. For instance, Analyst 1 stated that the CT usually provides the analyst with information about how the client tends to be perceived by others outside of therapy, while

Analyst 2 highlighted the uniqueness of the therapeutic relationship or the unique connection between analyst and client as being an important determinant of CT. This variability makes one re-consider, once again, what exactly are researchers and therapists talking about when researchers and therapists talk about CT? Finally, the current study is also limited by the problems attendant to retrospective, self-reported data.

Clinical Implications

This study has several implications for clinical work. Most importantly, and perhaps obviously, is the need for analysts and therapists to be mindful of their internal processes (including physical sensations) *in relation to* the client's experience. In particular, it is important for therapists to try to observe, understand, and care for those personal, wounded parts in the therapist that get triggered in-session. Furthermore, results suggest therapists be especially careful to not get too psychologically/emotionally distant from the client and, crucially, to develop a good therapeutic relationship. The flip side of this, of course, is that therapists also watch out for excessive empathizing or identifying with the client. Taken together, the challenge for therapists seems to be how to maintain a good working relationship while optimally navigating the space between client and analyst.

This study brings the analytic frame to the fore. Therapists may benefit from consideration and re-consideration of how factors such as time, schedule, client breaks and payments, for example, may be affecting the therapy, and what could or should be done to modify these frame-related factors in light of each case. Results suggest therapists stay open to considering an array of factors that may in fact be influencing transference-countertransference dynamics. These factors include, but are by no means limited to, cultural and gender differences between client and analyst, as well as any transpersonal elements at hand.

This study also has implications for clinical training and supervision. Trainees may be reassured to know that even experienced therapists wrestle with CT and that CT stemming from therapists' psychological wounds is oftentimes simply part of the therapeutic process—a part that, in fact, may be of therapeutic value. Student trainees, usually quite focused on what they can do to help the client, may at times benefit from turning inward and examining what "sore spots" have been triggered in their own psychology. The notion of helping others by helping oneself is therefore apropos, an idea which may advance dialogues on student mental health and clinical training. Moreover, this study highlights the potential usefulness of therapists' somatic CT. In general, students seem to be trained to focus more on what they *think* or *feel* (emotionally-speaking) about a particular client, less on what physical sensations they may be experiencing when sitting with a client. Trainees (and ultimately their clients) may benefit from being more mindful of bodily changes (e.g., shallower breathing, developing goose-bumps, feeling hotter or colder) in-session while working with supervisors to understand the origins and meanings of the bodily changes in order to better treat the client.

This study also provided some evidence of transpersonal factors at work in the analysis. In certain instances, supervisors and trainees—particularly when feeling "stuck" about a client—may benefit from widening their views, or at least being open to the possibility that other, larger, perhaps transcendent forces are operating in the transference. Potential implications of allowing for more expansive viewpoints may be that transference-countertransference discussions will include talk about *something else*, a *third thing* getting played out between the trainee and client that extends beyond the typically-considered intrapsychic and interpersonal factors, and beyond the experiential/historical antecedents of the client's difficulties. Opening up

space to consider transpersonal influences may therefore, in some cases, generate new meanings and understandings that prove valuable or useful to the analytic work.

Directions for Future Research

Directions for future research include continued studies, both qualitative, quantitative, and mixed-methods, about Jungian analytic process in general. This includes, but is not limited to, making use of a larger sample to further investigate how Jungian analysts experience, understand, manage, and make use of CT in actual practice. It may also be helpful to gather more data, perhaps by survey methods, on how Jungian analysts define CT and what importance they place on attending to and using CT in the analytic work.

Furthermore, future research on both Jungian and other kinds of analysis/therapy may further address and perhaps provide additional support for some of the findings in this study such as the role of modifying the analytic frame in CT management, the effects of cultural and gender differences between analyst and client on CT, the phenomenology of positively valenced CT such as empathy, the phenomenology of body or somatic CT, the role of client factors in buffering CT behavior, and the effect of spiritual or transpersonal factors on transference-countertransference dynamics.

The current study represents a step towards addressing the significant shortage of empirical research on Jungian psychology and psychotherapy. By exploring the ubiquitous, transtheoretical, and clinically-important phenomenon of CT, this study lays the groundwork for further discourse between Jungians and non-Jungians. Moreover, the fact that this study's findings were largely consistent with mainstream CT research suggests that perhaps Jungian practitioners have more in common with other approaches than some may think—reason enough to continue shining light into the inner world of the Jungian analyst.

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Appendix A: Participant Recruitment Announcement

Date_____

Dear, _____

My name is Jeffrey Burda and I am a clinical psychology doctoral student at Antioch University New England (AUNE). For my dissertation project, I'm conducting a study about Jungian analysts' countertransference experiences, focusing on analyst personal factors that may affect the analytic process. The main purpose of this study is to gain a deeper understanding of "what it's like" for Jungian analysts to deal with personal feelings, thoughts, and behaviors while working with clients. Please see the attached documentation of AUNE Human Research Committee's approval to conduct this study.

I'm now in the process of recruiting IAAP certified Jungian analysts who are currently in practice and who are willing to discuss their experiences working with a past client. I've chosen to contact you because you've either been recommended by another analyst as being potentially interested or you were found in an online membership listing of Jungian analysts for the New England Society of Jungian Analysts or the New York Association for Analytical Psychology.

Participation primarily involves the completion of one interview and a brief follow-up session. I have included the list of interview questions and the informed consent for you to review.

If this study is of interest to you, please contact me at jburda@antioch.edu or 860-871-8106 or 860-830-9023, including your telephone number and the best time to reach you. When we talk, I will review the terms of the study and answer any questions that you may have. Then, if you'd like to participate, we will establish a time to conduct the interview and determine the best way for you to complete the informed consent and two brief questionnaires (to be distributed later).

Lastly, if you know someone else who might be interested in participating, please feel free to either let me know or pass this information along.

Thank you for considering this invitation to participate in my dissertation project.

Sincerely,

Jeffrey M. Burda, MA

Appendix B: Semi-Structured Interview Protocol

Interview Introduction

In preparation for the interview, please choose to discuss a past (not current) client with whom you engaged in analytic work.

In addition, the following criteria must be met:

A. Working with this client elicited personal reaction(s) (e.g., thoughts, feelings, behaviors, fantasies, images, dreams, or bodily sensations) that made analysis challenging or difficult in some way.

B. Insofar as you were able to tell, this personal reaction(s), at least in part, was somehow rooted in your own psychological material or personal "stuff" (e.g., unmet needs or strivings, unresolved conflicts/issues or "unfinished business," psychological "wounds," vulnerabilities, or "blind spots").

C. You worked with this client for at least one year.

Please keep in mind that the client you discuss need not necessarily be a "successful" case – any case that fits the foregoing criteria is fine.

As a reminder, please also omit information that may identify this client.

Do you have any questions before we begin?

Interview Questions

Please think about an analytic case that elicited personal reaction(s) (e.g., thoughts, feelings, behaviors, fantasies, images, dreams, bodily sensations, etc.) that made the analytic process challenging or difficult in some way. This personal reaction(s), at least in part, stemmed from something in your own psychology (e.g., unmet needs or strivings, unresolved conflicts/issues or "unfinished business," psychological "wounds," vulnerabilities, o r "blind spots").

Please bring to mind a specific challenging time or period working with this client. If there was more than one period, try to focus on the one that most stands out for you. If you have trouble recalling specific time periods, please just do your best to describe whatever challenges you can remember about working with this client.

1. Please begin by discussing how you tend to define the phenomenon of countertransference in your day to day practice.

2. Please tell me a little about your past client, including his/her main problem(s) or issue(s) that you worked on over the course of analysis.

Now, thinking about this challenging period:

3. What personal reaction(s) did the client evoke in you? Please describe what the experience was like and how it made analysis difficult or challenging.

4. What was going on in analysis at the time you experienced these personal reaction(s)? (e.g., What were you working on? What did your relationship with this client look like?).

5. How did you come to understand or make sense of your personal reaction(s) -including the contribution(s) from your own psychology?

6. How did your reaction(s) influence the analytic process?

A. How, if at all, did your personal reaction(s) aid or help the therapeutic process?

B. How, if at all, did your personal reaction(s) obstruct or hinder the therapeutic process?

7. Please describe how you dealt with or managed your personal reaction(s) – including how "successful" or "unsuccessful" you were at managing these reactions over time.

8. What, if anything, did you explicitly disclose to your client about your reaction(s)? What was this like for you?

9. Did these personal reaction(s) "carry over" to your life outside of the therapy room? If so, please discuss your experience including any efforts on your part to deal with it.

10. In what way(s), if any, did working with this client affect you or change you as a person? as a professional?

11. What, if anything, would you do differently now in working with this client?

Appendix C: Demographic Questionnaire

1. Name: _____ 2. Phone: _____

3. Address: _____

4. e-mail_____ 5. Sex_____ 6. Age_____

7. Best way and time(s) to reach you? _____

8. Race/Ethnicity (please choose one):

_____ African American/Black _____ European American/White

_____ American Indian/Alaskan Native _____ Latina/Latino

_____ Asian American/Pacific Islander _____ Other (please specify):_____

9. Highest Degree completed_____ Year obtained_____

10. Location of Analytical Training_____ Year completed_____

11. How long had you been practicing pre-analytical training? _____ years ____months
Post-analytical training? _____ years _____ months

12. How long in your own (personal) therapy or analysis? _____ years _____ months

13. Type(s) of therapy or analysis you have received? _____

14. In addition to Jung, please list any other theorists or paradigms of thought/ systems of belief (psychological, spiritual, religious, etc.) that influence your work with patients:

_____ _____

_____ _____

_____ _____

_____ _____

Thank you,

Jeffrey M. Burda, M.A., Principal Investigator

Appendix D: Client Information Questionnaire

Client's age (at start of analysis) _____

Client's sex _____

1. How long did you work with the client altogether? _____ year(s) _____ month(s)

2. How long ago did you "terminate" with this client? _____ year(s) _____ month(s)

3. How many days per week did you typically see this client? _____ day(s)/week

4. How long had you been working with this client before this challenging period occurred?

5. How long did this challenging period last? _____ day(s) _____ month(s) _____ year(s)

6. Overall, how did this client do in analysis with you? (please choose one)

Greatly improved	Moderately improved	Slightly improved	No change	Slightly deteriorated	Moderately deteriorated	Greatly deteriorated
3	2	1	0	-1	-2	-3

7. Briefly, what changes (if any) did you notice in him/her?

_____

_____

_____

_____

Thank you,

Jeffrey M. Burda, M.A., Principal Investigator

Appendix E: Consent Form

Project Title: **Wounded Healers in Practice: A Phenomenological Study of Jungian Analysts' Countertransference Experiences**

Principal Investigator (PI): **Jeffrey M. Burda, M.A. (doctoral candidate)**
Department of Clinical Psychology
Antioch University New England
40 Avon Street
Keene, NH 03431

Dissertation Chair: **James Fauth, Ph.D.**
Department of Clinical Psychology
Antioch University New England
40 Avon Street
Keene, NH 03431

This project is a research study, intended to understand the phenomenon of personal countertransference from the perspective of a practicing, certified Jungian analyst.

If you choose to participate in this study, you will be asked to:

- complete two brief questionnaires, one gathering demographic information about you, and a second asking 7 questions about a client you will select. The total estimated time to complete these two questionnaires is about 10 minutes, and you may return them to me by either e-mail or postal mail.
- be interviewed (either in-person or by telephone, whichever is more convenient for you) to discuss your personal experiences working with a past client. The interview is expected to take 60-90 minutes. This interview will be audio recorded and later transcribed, for purposes of data analysis.
- participate in a brief follow-up session via e-mail or telephone, to review and provide feedback concerning the themes I perceive in our interview. This feedback session is expected to require no longer than 20 minutes of your time.

Risks of participation
It is possible that you could encounter some discomfort while discussing your personal experiences of countertransference.

Benefits of participation
Although this study is not designed for the benefit of the interviewees, you may experience greater understanding of yourself and your work, as a result of your participation. You will also assist me in trying to advance general knowledge about countertransference in our field. You will receive a $25 gift certificate to Amazon.com as compensation for participating in this study.

Your participation is voluntary, of course, and you may withdraw from this study at any time and for any reason, without explanation if you so choose. If you begin the study and later decide to withdraw, you will still receive the $25 gift certificate.

We will take the following steps to protect your privacy:

1. Your written and verbal (recorded) responses will be identified only by a code number, with the list of codes and names kept in a separate location from all physical and electronic data. All physical documents and audiotapes will be stored in a locked filing cabinet in a locked office, with only the PI having access to the files. All electronic data will be kept in a password-protected file on a password-protected computer, in a secure location.

2. The PI is the only person with knowledge of these passwords and the only person having direct access to this confidential information. One additional research team member acting as a second coder for reliability purposes will have access to typed transcript material. Transcript material will be identified using a code number only. Finally, the Antioch University Institutional Review Board as well as the PI's Dissertation Committee may also have access to data upon request.

3. All audio recordings will be destroyed at the end of this project.

4. I expect to publish the results of this study in both my dissertation and future scholarly publications and presentations. In any written report of the results, names and other potentially identifying information will be omitted and/or sufficiently altered so as to protect you and your client's privacy. You will be offered an opportunity to review and correct the transcripts of my interview and comment on a draft of the final results of this study. You will also be offered the opportunity to review and veto inclusion of any direct quotes that I've decided to include in my initial draft of the report.

If you wish to receive a copy of the study results, and/or a copy of your transcribed interview, please inform Jeffrey Burda today or at any time before the conclusion of the study, as instructed below.

If you have further questions after our discussion today, you may reach, Jeffrey M. Burda, Principal Investigator, at (xxx) xxx-xxxx or (xxx) xxx-xxxx or via e-mail at jburda@antioch.edu.

If you have any questions about your rights as a research participant, you may contact Dr. Katherine Clarke, Chair of the Antioch University New England IRB, (603) 283-2149, or Dr. Stephen Neun, Antioch's Vice President for Academic Affairs, at (603) 283-2150.

I have read and understand the information provided and agree to participate in this study.

_____	_____	_____
Printed Name	Signature	Date

Appendix F: Post-Interview Thank you/Reminder Letter

Date_____

Dear _____,

I'm writing to thank you once again for participating in my dissertation research. Your thoughtful responses will certainly add to our understanding of the interactions between analyst and client in Jungian analysis.

I also want to remind you that after your interview is transcribed and coded over the next few weeks, I will e-mail you a list of the most salient themes that emerged from your interview.

When you receive the list, please review it and provide me with feedback regarding the degree to which I accurately captured what you meant to convey in your responses.

In the meantime, if you have any questions or concerns, please call or e-mail me.

Sincerely,

_____

Jeffrey M. Burda, MA
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*Remember as well that you can always contact me if you'd like me to send you a copy of this study's results.

Appendix G: Table 1

Superordinate Themes and Themes from Analysis

Superordinate Themes and Themes	**Participant(s) Number**	**Examples from Interview Narratives**
1.**Countertransference has Origins in Analyst's Wounds**		
Wounds Rooted in Personal History	A1, A2, A3, A4, A5, A6	"[The client] went a number of times to (specific event) and that raised a little envy in me (CT) because that's a place, that's something I'd always wanted to do and never, never made it" (A1).
		"I'd had my own developmental trauma around…inability to maintain my own boundaries, constant boundary onslaught…so [the client's] penetration into my *psychic* space, into my *temporal* space…[caused CT that] was very difficult to contain, just in my own process" (A5).
Wounds as Complexes	A1, A2, A3, A6	"It [the client's behavior] tapped into that entitlement complex in me, right? Like, 'what am I entitled to?', 'what can I get?', 'what can I have?', 'like, I'm you're your servant,' all of those things kind of go together…so *that's* where it got me in the countertransference" (A2).
		"[The client] came every week and out of that, the issue around my countertransference - my own woundedness here - there were several big issues, one was the mother and the other was the father, surprise!...gradually, as [the client] became more conscious and more capable of discussing and disclosing what was going on, the focus [in analysis] became on the father, and [then] it was my father complex that got injected into the analysis" (A6).

(table continues)

Table 1 (continued) **Superordinate Themes and Themes**	**Participant(s) Number**	**Examples from Interview Narratives**
2. **Countertransference Triggers**		
Client Similarities	A3, A6	"I had gone through my own experience of divorce and so part of it was just [*the client's*] *own* attempt to make sense of it [the client's divorce] and come out of it with a sense of self-worth had been reacting with *my own* need to do this" (A3).
		"Where *my* complex entered [into analysis] with *my* father was that my father was a similar kind of person. In fact, this client *looked* like my father…[the client] *looked* and acted like my father" (A6).
Projections from Client	A2, A4, A5	"I know it's [CT reaction] gonna be negative, 'cause [the client] has a negative mother transference, which is, you know, barely concealed" (A2).
		"And [I felt] very unguarded and thought that I might tear (CT)…and there is no question in my mind that that was a positive projective identification. I think it was quite possible for [the client] to transmit that sadness to me and for me to 'pick it up' in a way that was not overpowering" (A5).
Client's Troublesome Interactive Style	A1, A2, A5	"So [the client] was *capable* but what [the client] was always trying to do was get free money…always trying to find a way to get money without working…[so] after a while, it impacted the fee, it impacted [the client], I guess, turning on the 'I'm a needy person'…[the client] was building up a case for being weak…[and] I agreed to stay at a low fee (CT) at a time when I was raising my fee with other patients" (A1).
		"[The client] comes and [the client] doesn't want to listen and [the client] 'knows it all,' you know, 'cause [the client] knows [the client's] smart…like 'you [the analyst] can't help me,' because either you don't have enough knowledge, or because you don't know how to do good mothering, and so it bothered *me*, I think, in the countertransference…[it was] part of that irritation I was talking about" (A2).

Table 1(continued) **Superordinate Themes and Themes**	**Participant(s) Number**	**Examples from Interview Narratives**
3. **Manifestations of Countertransference**		
Analyst's Full Engagement with Client is Disrupted	A1, A2, A3, A5, A6	"I couldn't tolerate, in the countertransference, it was hard to tolerate, like, *movement*…'cause I felt like I wanted to break free…and I would just flicker and fall away [from the analysis]…I could not hold the ground on keeping a constant understanding of what was going on in the transference and what I was experiencing in the countertransference to have me sit with [the client] and have it be okay" (A2).
		"I felt hypervigilant, perhaps is a good word, thinking 'oh my god, is this person [the client] spying on me? There was a paranoid feeling just in the moment and I think that was part of the…and that has *never* happened to me with a client before where I felt, am I being…? Has this person somehow gained access to my life? So that was quite powerful. [And so] we [client and analyst] stumbled. I asked [the client] to repeat the dream. I said I was having a little bit of difficulty following some of the content in it" (A5).
Analyst Wishes to Care for Client	A2, A5, A6	"In the countertransference, something comes up in *me* that says, 'I *can* support you [the client],' 'I *can* help you,' 'I *can* take care of you'…so I think it triggers in *me* that caretaker complex, like that, 'I can be a good mother to you.' And most of my other, like my other patients, I don't get that. Actually it was with [*this client*]. [This client] was one of two patients that I can clearly say that I got that experience in the countertransference, like *really wanting* to take care of somebody, feeling like I could be the 'good mother' to you" (A2).
		"There were times when in the midst of that highly-organized, logos-like persona [of client], I would find myself feeling *sad*, *compassionate*, *loving* [towards client], not the usual response" (A5).
Analyst is Drawn into a Spiritual Experience	A4	"I was much more pulled toward [the client's] spiritual side…this [CT experience] took me *totally out of my body*. It was one of the problems because it became *totally* spirit, not body…[the client] would, in effect, take me into this spiritual experience that [the client] was having…."

Table 1 (continued) **Superordinate Themes and Themes**	**Participant(s) Number**	**Examples from Interview Narratives**
4. **Countertransference Effects**		
Negative Effects on Analytic Process/Outcome	A1, A2, A3, A6	"I think I let it [the analysis] go too long…I [eventually] *arrived* at a place that I probably should have been much earlier on and been a lot harder on [the client] but my countertransference got in the way because I'm a rather sympathetic type" (A1).
		"There may have been a little more caution in me that made us a little more careful and might have slowed the process somewhat…slowed the process of trust and relationship perhaps or openness and comfort…that's the primary one [effect of CT] that I would say was obstructing, or not even obstructing, more like hindering, or slowing [the analytic process]" (A3).
		"Back then, I actually felt guilty [about confronting client], even though I knew it was the correct thing to say. But one of my growth points was to not worry so much, like a surgeon can't worry so much about making a cut. I fear being penetrating too quickly but, in this case…in looking back, I feel that part of the reason why the therapy probably was *not* as good as it could have been was that I was not strong and penetrating enough, that I didn't call [the client] on [the client's] shit early enough" (A1).
Strengthened or Weakened the Analyst-Client Bond	A2, A3, A5, A6	"Of course, I would want this patient to *like* me. I want [the client] to like the work. I want [the client] to come, to do the work. I want this to be a good space for [the client] to work. Not for me to *make it good*, but for [the client] to join with me in an understanding of how it *can* be good for [*the client*]…[but] we couldn't get a good bond going. We never bonded well. And that's from the mother, from [the client's] mother (referring to client's negative mother transference)*"* (A2).
		"I think it [analytic bond] was related to another aspect of the transference that connects to the mother, was that I really liked [the client] and [the client] really liked me, you know, on a deep level I really loved [the client]" (A6).

Table 1 (continued) **Superordinate Themes and Themes**	**Participant(s) Number**	**Examples from Interview Narratives**
Analyst Gained Confidence in Handling Countertransference	A2, A3, A5, A6	"As a professional, I think it [this analytic case] was a good experience of learning and of developing confidence in my ability to deal with this kind of [CT] process…at this point, I think I have more ability to watch the process without getting triggered than I did even then" (A3).
		"[The client] taught me a great deal. I mean, [the client] taught me how to work *much* more flexibly and in a multifaceted way with the countertransference, indeed [the client] did…[I'm now] *so much* more flexible. *Much* less threatened. *Much* more *attuned* to countertransferential dynamics. Not a lot of battles about self-disclosure because I'm right up front, because I'm a little bit [more] relaxed about that" (A5).
Mutual Healing and Transformation	A5, A6	"All those things created an environment [in analysis] that was unforgettable for which I am *very* grateful because it was such a powerful learning experience and ultimately where, as Jung said, 'both were changed'" (A5).
		"Yeah, both [the client and I] were healed, both were changed…we became more conscious together of the father, we unlocked things together, see. But neither one of us had the key until *well* into our relationship…I was healed. I was healed…it was one of the fruits of working with [the client]…it's made me more patient" (A6).
5. **Countertransference Management**		
In-Session Modulation with Awareness and Understanding	A2, A3, A4, A5, A6	"I had to watch if any of my own insecurities about powerful women were triggered…in a sense it's both understanding what was going on with me and watching my responses-watching any emotional reactions, watching any physical responses" (A3).
		"Part of the calmness for me in session with a client is to be aware of the things that might make me clench and be less so" (A5).

Table 1 (continued) **Superordinate Themes and Themes**	**Participant(s) Number**	**Examples from Interview Narratives**
Analyst Works on Personal Self throughout Analysis	A3, A5, A6	"I think a lot of it is noticing my [CT] reactions and being conscious of enough of them, and working on myself enough, that they don't get in the way. And I think for the most part, in this case, they did not interfere that severely. [I was engaged in] my own *self*-analysis during much of that time…and was not in a personal analysis. But there was a constant self-work, work with colleagues and processing of this material" (A3).
		"On my own during that period [of analysis with the client]…I wasn't trying to be unconscious [of my CT], see. At the same time during that period, I also became more conscious of my own father and I was working on him in my own…I wasn't in analysis, but in my own dream-work and so on. So I was *catching up* in a sense [to the 'father-work' my client was doing]. It was sort of a mutual operation" (A6).
Modifying/Adapting the Analytic Frame	A1, A5	"I resisted seeing [the client] four times a week [in the beginning] because I didn't think I could handle another session with [the client] every week [but, the client] *wanted* to come four times a week…and so we started with three-time-a-week work, which was unusual for me at that time in my practice, and then finally, when the work took on more dimension and I felt secure in it (referring to the ability to cope with CT), we did go up to four times a week" (A5).
6. **Contextual Factors in Analysis**		
Time Factors or Considerations	A1, A2, A5, A6	"I mean, certainly a brief encounter, brief intense work can also be transformative, but I think again, the [great] length of time, the duration and the frequency (of the work with this client helped the transformation process)" (A5).
		"It would be like if you knew somebody for (several decades) and you chewed the fat with them every, you know, for hours, and hours, and hours and you shared things and things got better for both [of you]" (A6).

Table 1 (continued) **Superordinate Themes and Themes**	**Participant(s) Number**	**Examples from Interview Narratives**
The Unconscious or Some Other Transcendent Power	A2, A4, A5, A6	"Oh my God, how can we deny its existence (a transcendent power)? Well, anybody can deny its existence who wants to. I cannot…I think there's some sort of deep karmic connection [between me and this client]" (A5).
		"And it [client's dream] changed [the client's] whole…that was the key to the resolution of the father thing, you know. And [the dream was for] me [the analyst] too! It was very, very, very moving" (A6).
Cultural Factors	A1, A2, A3, A6	"I would say it's a sort of a common, *collective* response of women, almost wanting to make sure they don't become dependent and they're not too much caught in their own transference, and that when [the client] was dealing with [the client's] anger, that it doesn't trigger my own insecurity about the decisions I made."
		"If you deal with men, if you consult other older men…[you'll notice that] men do [over time] begin to see their fathers differently. I think it may be sort of a natural process 'cause…initially you have to 'slay the father' to become your own man. You have to leave your father, you have to push him aside, push aside his manhood and take up your own. And that's necessary. Otherwise, you're just daddy's little boy forever. And it takes twenty, thirty…it takes ten, fifteen, twenty years to do that."