A Qualitative Study of Therapists' Experiences of Countertransference when Working Therapeutically with Children and Families.

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Abstract

The concept of countertransference (CT) originated within psychoanalysis in the 1900s and is considered an important therapeutic tool in psychodynamic therapies today. With increasing emphasis on the therapist's role in the therapeutic relationship and on treatment outcomes, CT is increasingly being talked about and recognised in other therapeutic disciplines. While there is ongoing debate about the definition of CT, it is generally understood to be the emotional, cognitive, physiological and behavioural reactions therapists experience in response to clients within the therapeutic relationship. There is evidence that CT is a process that is common to all therapists, regardless of theoretical perspective, training or years of experience. CT is considered to affect the therapeutic relationship, working alliance and treatment outcomes in both individual and family therapy. Importantly, how CT is managed by therapists is critical in determining therapeutic progress and outcomes.

Significantly less research examining the nature of CT in family therapy has been undertaken. This may be due to early attempts by researchers and practitioners in family therapy to differentiate the field from psychodynamic paradigms and to assume a position in which the therapist remains emotionally neutral. However, it is believed that the role CT plays in family therapy is equivalent, if not larger, due to the increased number and complexity of relationships. This thesis is a qualitative exploration of therapists' understanding and experiences of countertransference (CT) when working therapeutically with children and families in New Zealand. In particular, this study examined the family behaviours, therapist sensitivities and therapy situations that triggered CT in therapists and the nature of the reactions associated with these. It also investigated the strategies therapists use to manage their CT, as well as the impacts they perceive CT has on themselves, their clients, the therapeutic relationship and treatment outcomes.

Fourteen therapists (11 clinical psychologists, 1 psychiatrist and 2 psychotherapists) were recruited for this study. The study sought therapists working in all modalities, who had worked with children and families within the last 18 months, and for a period of at least two years. Twelve identified as female and two as male. The therapists were interviewed using a semi-structured interview format about their experiences of CT when working with children and families. The data from the interviews were analysed using the process of thematic analysis.

The results of the thematic analysis revealed that therapists viewed CT as emotional responses that are normal and inevitable. They also viewed countertransference as a relational process and an important source of information about themselves and the client family system. These aspects of understanding relate to different theoretical perspectives of CT, including psychodynamic, cognitive-behavioural therapy and family therapy orientations. CT was understood to be interpersonal, occurring in the space between therapists and their clients, coming from a combination of both client and therapist contributions. However, many therapists felt limited in their opportunity to talk about CT with colleagues, due to the absence of a shared language and the stigma associated with CT.

Therapists reported a range of CT reactions that were triggered by five main child and/or family behaviours and therapy situations. These included when parents are critical and angry, when families want help but disregard therapists' input, when children are or have been at serious risk, when families lack resources and being friendly or idealising the therapist. These triggers activated emotional, cognitive and behavioural responses in the therapists. In terms of managing CT, therapists spoke about the importance of awareness and reflection, and within-session management strategies such as grounding and emotion regulation skills. Talking with colleagues, supervisors and their own personal therapists were also important to assist them with managing their CT reactions. Additionally, all therapists described utilising their CT reactions by disclosing some of their responses to and clients when they thought this would be therapeutically appropriate and beneficial. Finally, the results of the study support and add to the existing literature on the benefits of managing CT reactions and the adverse effects of not being aware of and managing CT. This study contributes to the literature on CT in child and family therapy, and considers limitations, clinical implications for practice and future research directions.

Keywords: Countertransference, Children, Family Therapy, Qualitative Research

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Chapter One – Introduction, Literature Review and Purpose

This thesis study is a qualitative investigation into therapists' conceptualisations and experiences of countertransference (CT) when working therapeutically with children and families. The term CT is most commonly used to refer to therapists' emotional-cognitive responses to clients, which occur within therapeutic relationships (Cartwright, 2004; Gabbard, 2004). Although CT originates from a psychoanalytic perspective, all therapists, regardless of experience level or theoretical orientation are thought to experience CT in response to their clients (Betan et al., 2005). CT is a common experience in therapy with adults (Hayes et al., 1998) and children and families (Hay et al., 2019). It was identified in 80% of 127 brief therapy sessions in a study of eight expert adult psychologists (Hayes et al., 1998) and experienced often by 59% of child and family psychologists (Hay et al., 2019). Importantly, therapists' CT can affect the therapeutic relationship, therapeutic outcomes and the well-being of clients and therapists depending on how it is managed by therapists (Gelso et al., 2002).

In individual therapy, CT makes up an important component of the therapeutic relationship (Gelso, 2014). According to the tripartite model of therapeutic relationships developed by Gelso (2014) all therapeutic relationships consist of three components. These are a real relationship, or the personal relationship between therapists and their clients as humans; a working alliance, or the joining of therapists and clients with the purpose of completing a piece of clinical work; and a transference-countertransference interaction, or the emotional-cognitive responses of clients and therapists (Gelso, 2014). These features are present in varying degrees in all therapeutic relationships, across diverse theoretical perspectives and orientations (Gelso, 2014). The literature consistently demonstrates that the therapeutic relationship is crucial, both to the change process, and to determining treatment outcomes of therapy (Guest & Carlson, 2019). There is evidence across the literature for the association between the therapeutic relationship and successful treatment outcomes regardless of variables such as treatment approach, type of outcome measure or type of rater (Karver et al., 2006; Leahy, 2008). This association between the therapeutic relationship and the treatment outcome is similar for children, adolescents and adults (Karver et al., 2006; Shirk & Karver, 2003). The therapeutic relationship has been considered less in family therapy

(Flaskas, 2004). In addition, the relationship-outcome association is harder to measure in family therapy due to the number and complexity of relationships. However, the available literature suggests that the therapeutic relationship is equally important in family therapy in determining treatment outcomes (Joseph, 1996; Karver et al., 2006; Lyness, 1998). CT, a component of the therapeutic relationship, is therefore an important area for all therapists to understand theoretically and clinically.

CT is also associated with other aspects of the therapeutic relationship, notably the working alliance. Negative CT can adversely affect the working alliance, the aspect of the therapeutic relationship that relates to the capacity to mutually agree and collaborate on the goals and tasks of therapy (Ligiéro & Gelso, 2002). The working alliance is consistently and robustly associated with treatment outcomes in two separate 2018 meta-analyses for both individual therapy (Flückiger et al., 2018) and family therapy (Friedlander et al., 2018). Although considerably more research has been conducted on the alliance-outcome in individual therapy (e.g. 295 studies in Flückiger et al., 2018 versus 48 studies in Friedlander et al., 2018), this relationship has been found to be similar in family therapy ($r = .297$ in family therapy versus $r = .278$ in individual therapy). Stronger alliances contribute to greater treatment retention, session evaluations and improvement in family well-being (Friedlander et al., 2018). Conversely, split or unbalanced alliances in which at least one family member has a stronger bond with the therapist than do other family members, contribute to significantly worse treatment outcomes (Friedlander et al., 2018).

Although the impact of CT on the working alliance has been studied in some depth for individual therapy (Hayes et al., 2015; Ligiéro & Gelso, 2002), there is a lack of research into this relationship for family therapy. However, Friedlander, therapist and researcher in family therapy, and her colleagues argue that the occurrence of CT is more common in family therapy (Friedlander et al., 2006). Moreover, therapists have to develop and nurture multiple alliances simultaneously in family therapy, including with each individual, sub-system and family as a whole (Friedlander et al., 2011). Due to the increased frequency of CT and the larger number of alliances, it appears that there is greater potential for CT to adversely affect the working alliance and therapeutic outcomes in family therapy.

Crucially, the way therapists manage their CT experiences can greatly influence therapeutic relationships and therapy outcomes (Hayes et al., 2018). Hayes et al. (2018) completed a comprehensive meta-analytic review of the research on CT, its management and

the relationship of both with therapy outcomes. They concluded more frequent CT reactions are associated with poorer therapeutic outcomes, and better CT management is associated with fewer CT reactions as well as larger gains in therapy outcomes. Gains in therapy outcomes include benefits to the client such as improvement in client functioning (Gelso et al., 2002); benefits to the therapist, such as more in-depth understanding of the client (Hayes et al., 2015); and benefits to the therapeutic relationship through strengthening the working alliance (Hayes et al., 2015; Ligiéro & Gelso, 2002; Rosenberger & Hayes, 2002).

Conversely, when therapists are not able to effectively manage their CT reactions, their therapeutic relationships and therapy outcomes can be adversely affected (Gelso & Hayes, 2001). Therapist displays of CT are associated with reduced working alliance (Ligiéro & Gelso; 2002), hurting the clients' feelings, over-involvement of the therapist (Hayes et al., 2015) and the termination of therapy from both adult clients (Hill et al., 1996) and families (Shapiro, 1974). CT can negatively affect the therapeutic process and outcomes in a number of ways. It can lead therapists to focus on their own needs rather than their clients' needs (Ligiéro & Gelso, 2002), interfere with therapists' accurate perception of the working alliance (Ligiéro & Gelso, 2002), and interfere with therapists' understanding of clients. This can lead therapists to misperceive clients, inaccurately conceptualise cases and/or wrongly diagnose and make poor treatment choices (Hayes et al., 2015). Moreover, CT can negatively affect therapists personally by causing high levels of stress and burnout. As a result, therapists may need to take time off work and their therapeutic ability may be reduced (Ingley-Cook, 2019). Away from the work place, CT can cause sadness, anger, sleeplessness and exhaustion and affect therapists' personal relationships if not managed effectively (Ingley-Cook, 2019).

The published research on CT to date has predominantly focused on individual therapy, largely with adult clients. The previously mentioned meta-analysis exclusively examined studies that focused on individual therapy (Hayes et al., 2018). Research exploring CT when working therapeutically with children and families has been limited, despite suggestions that CT is both more common and stronger for therapists who work with children (Dubé & Normandin, 1999; Gabel & Bemporad, 1994) and families (Friedlander et al., 2006; Kohrman et al., 1971). This study therefore seeks to add to existing research and clinical literature, by examining the CT experiences and management of 14 therapists who worked with children and families. Compared to internationally, family therapy is a less recognised and regulated profession within New Zealand (Kumar et al., 2012). Due to limited training

opportunities in family therapy, most family therapy practitioners have their core training in other disciplines, predominantly clinical psychology. In New Zealand and Australia, cognitive and behavioural therapies are a prominent aspect of clinical psychology training programmes (Kazantzis & Munro, 2011). As such, many therapists in this study were practicing from cognitive, behavioural and related approaches. However, the focus of families and their involvement in treatment has grown within New Zealand, and the importance of inclusion of families in the care of children and youths is widely recognised and encouraged in the therapeutic setting (Kumar et al., 2012).

Chapter One provides an overview of the relevant literature that forms the context for this study. The second chapter outlines the methodology used in the study. Chapters Three and Four present the results of the thematic analysis relating to therapists' conceptualisations of CT; the triggers of CT and the nature of these reactions; the ways therapists manage and utilise their CT; and the perceived impacts of CT on the therapeutic relationship and process. Finally, Chapter Five discusses the results of the study and its contribution to CT literature, along with the implications, limitations of the study and suggestions for future research.

The next section of the present chapter begins with an overview of the conceptualisations of CT across time and therapeutic perspective, beginning with its origins in psychoanalysis. This will include psychodynamic, cognitive-behavioural and family therapy perspectives of CT. The second section examines therapists' experiences of CT when working individually with adult clients, along with their strategies for managing CT. The third section of the chapter explores the experiences and management of CT for therapists working with children and families. Each section includes the relevant research and clinical findings and observations. Finally, this chapter will present the rationale and aims for the current study.

Conceptualisations of Countertransference

Psychodynamic Perspectives of Countertransference

The Classical View

The concept of CT originated within a psychoanalytic perspective with Freud in the early 1900s (Freud, 1916). Freud used the term CT to refer to analysts' emotional responses that occur unconsciously in response to clients' transference (Freud, 1916). First developed by Freud in the 1890s, the concept of transference refers to a process through which a client transfers feelings associated with previously important people, usually from their childhood, onto the analyst (Freud, 1912). Using this view, CT can be understood as the analyst's transference to the client's transference (Gabbard, 2001). CT was considered to be an unconscious process arising from the analyst's own unresolved inner conflicts (Hayes et al., 2018). Freud perceived these unconscious reactions as a hindrance to the therapeutic process unless they were overcome (Freud, 1916). This conceptualisation of CT is now known as the classical view. Although the conceptualisation of CT has evolved over time, it is important to recognise its history, as this still informs the way in which many therapists view CT today. Freud's emphasis on the need to overcome CT may have contributed to the field's neglect of the topic for a significant period of time, as it was viewed negatively and as a potential impediment to therapy (Hayes et al., 2018).

The Totalistic View

In the 1940s and 1950s, a number of psychoanalysts, most notably Heimann (1950), re-examined the concept of CT. Heimann (1950) viewed CT as all of a therapist's emotional reactions towards a client, a perspective now known as the totalistic perspective. According to this perspective, CT can occur in response to any of a client's internal or external behaviours, personality, appearance or the content of a session (Heimann, 1950). Although this view is broader in scope, Heimann (1950) considered CT as more useful within a therapeutic context as it provides important information about a client. CT is thus considered an important tool for understanding a client's internal world and providing insight into their unconscious (Cartwright, 2022). This is because Heimann (1950) believed that a therapist's

unconscious could understand aspects of their client's experience faster and in ways that the conscious mind is unable to. Even though CT was considered to be useful information, Heimann did not support therapists communicating their CT feelings to their clients (Gabbard, 2001). She believed that to do so could burden clients or distract them from therapy (Cartwright, 2022). It is argued that this totalistic definition of CT is over-inclusive (Hayes et al., 2015) and without boundaries, rendering it scientifically unusable (Gelso, 2014). However, Heimann (1950) noted that it is important for therapists to understand which CT feelings are informative about the client as opposed to which CT reactions are more to do with therapists. Moreover, her shift in conceptualising CT was critically important in changing the existing attitudes about CT (Cartwright, 2022).

Objective and Subjective Countertransference

Also in the 1940s and 1950s, and within the totalistic perspective, CT was differentiated into two separate components. Winnicott (1949) differentiated between objective and subjective reactions. Objective CT refers to therapists' reactions to the observable personality or behaviour of clients (Winnicott, 1949). These reactions are realistic because other therapists and people in a client's life may share them (Cartwright, 2011). Objective CT can therefore provide clinically meaningful information to therapists regarding their clients' interpersonal behaviour and relationship dynamics. Conversely, the subjective component refers to therapists' responses to clients based on their own past, personal issues and unresolved history (Cartwright, 2011; Winnicott, 1949) and is described as more irrational (Kiesler, 2001). Subjective CT reactions occur when therapists' cognitive-affective responses to clients deviate considerably from the response of other therapists or clinicians (Kiesler, 2001). Therefore, though subjective reactions are important to identify and manage within a therapeutic context, they provide information about the therapist rather than about the client. According to this perspective on CT, it is important for therapists to acknowledge and differentiate between what therapists contribute to CT (subjective CT) and what clients contribute (objective CT).

The Relational View

The relational perspective, developed in the 1990s, emphasises the interpersonal and collaborative nature of therapy and CT and assumes that therapists and clients mutually influence one another (Safran & Kraus, 2014). The relational approach represents a shift from previously held views of psychoanalysis as a one-person psychology that focused on the intrapsychic world of a client (Cartwright, 2022). According to relational theorists, such as Aron (1990), relationships are central in psychopathologies and in therapy; therefore therapy should focus on the interpersonal world of the client, and the interpersonal interaction between clients and therapists (Cartwright, 2022). Relational approaches therefore view therapists and clients as co-participants in the creation of CT (Gabbard, 2001). They believe CT is a jointly created experience based on influences from both the client and the therapist (Gabbard, 2001). It is assumed that the therapists' contributions are equally important as their clients' contributions to what is occurring in the therapeutic relationship (Safran, & Muran, 2006). Relational theorists recognise the subjectivity of therapists' perceptions and emphasise an ongoing, in-depth exploration of therapist and client contributions to the interaction throughout therapy (Safran & Kraus, 2014).

The Integrative View

Leading CT researchers, Hayes and Gelso, termed the integrative perspective of CT. These authors define CT as therapists' reactions to clients that originate from the therapists' own unresolved conflicts (Hayes & Gelso, 2001). This view sees the source of CT as located within the therapist, encouraging therapists to identify and take responsibility for their reactions. In this view, the integrative perspective aligns closely with the subjective notion of CT in that therapist reactions are only considered CT if the source of the reaction are therapists' own personal issues (Hayes, 2004). On the other hand, if client characteristics or behaviours evoke therapist reactions (objective CT), Hayes and Gelso do not consider this CT, because they argue for defining CT in a way that differentiates reactions due to unresolved conflicts from 'normal' reactions or emotions (Hayes, 2004). However, Hayes and Gelso (2001) still view CT as a jointly created phenomenon that is shaped by both therapist and client factors. As CT can occur in response to a client's transference or other internal or

external behaviour of a client, the triggers and origins interact to elicit unique CT reactions (Hayes et al., 2018). The integrative perspective considers CT useful provided therapists understand the reaction and use this to help understand their clients (Hayes et al., 2018). As such, all therapist reactions are important to be aware of and explore. Hayes (1995) developed an organisational framework for CT, which breaks CT down into five components. These are (a) origins, the unresolved conflicts in the therapist that lead to CT reactions; (b) triggers, the events that occurred within therapy that activated these unconscious conflicts; (c) manifestations, the affective, behavioural or cognitive reactions of the therapist; (d) effects, or the consequences of the reaction; and (e) management, or how the therapist copes with the reaction (Hayes, 1998).

Cognitive-Behavioural Perspectives of Countertransference

Although the concept of CT originated within a psychoanalytic model, it is important to investigate how other therapeutic models, such as cognitive-behavioural therapy (CBT) understand and use CT, particularly when conducting research within an Australasian context. This is because of the prominence of CBT within clinical psychology training programmes in Australia and New Zealand, where the vast majority offer this training (Kazantzis & Munro, 2011). Furthermore, CT is now recognised as a fundamental aspect of all types of therapy, regardless of theoretical orientation (Betan et al., 2005).

There has been less discussion of CT within CBT, and little research is available on this topic (Westra et al., 2012). This may be in part because more emphasis has historically been placed on applying specific models and techniques in CBT (Haarhoff, 2006; Leahy, 2008), with CBT therapists generally placing less emphasis on the therapeutic relationship (Cartwright, 2011). Furthermore, the classical view of CT as based on the unconscious and rooted in the past contrasts with CBT's emphasis on the present (Haarhoff, 2006). However, recently there has been an increased focus on the therapeutic relationship and CT within CBT (Leahy, 2008), though this is often termed differently as therapist emotions, emotional response and emotional reaction of the therapist (Cartwright et al., 2016; Westra et al., 2012).

Leading CBT therapists and researchers, Aaron Beck and his colleagues (Beck et al., 2004), briefly acknowledged CT in their discussion of cognitive therapy with adult clients diagnosed with personality disorders. They referred to CT as the emotional reactions of the

therapist that occur during the therapy process, triggered by the client's behaviour and transference (Beck et al., 2004). This may be seen as similar to the objective view of CT in psychodynamic perspectives. Beck et al. (2004) suggested that therapists attending to their own emotional responses can "be bridges to change rather than barriers to progress" (p. 108). However, as well as the emotional responses of therapists, CBT perspectives also outline the important role of cognitions in CT, including the presence of automatic thought distortions about a client (Prasko et al., 2012). In this view, changes in emotional reactions are associated with changes in automatic thoughts, which can indicate CT is occurring. CT in CBT is also thought to be influenced by therapists' schemas about themselves, others, and relationships, which are all triggered by the clients' behaviour (Cartwright et al., 2016; Leahy, 2008). Interpersonal or relational schemas are considered the equivalent of CT in cognitive therapy by leading cognitive therapists and theorists such as Leahy (2008).

Schemas refer to mental structures that integrate different sources of information in order to make meaning of events (Haarhoff, 2006). Schemas generally relate to oneself and relationships with other people. Although they are formed during childhood, they continue to develop with the input of more information over a lifetime (Young et al., 2003). Emotional schemas include beliefs and strategies for making sense of, and responding to, different emotions (Leahy, 2008). The emotional schemas of therapists will therefore be triggered by clients and certain therapeutic contexts, and will influence how a therapist responds to a client. Haarhoff (2006) and Leahy (2007) describe common schemas of therapists which can result in CT responses. These are demanding standards, or the belief that there is one right way to do things in therapy; special superior person, or the belief that therapy is an opportunity to accomplish excellent results; and, excessive self-sacrifice, or the belief that a therapist should comply with their client's demands even when they conflict with those of the therapist (Haarhoff, 2006). Leahy (2007) additionally noted an abandonment schema, which relates to a therapist's belief that their clients will leave them. These schemas result in different CT emotions, cognitions and behaviours in the therapist when activated by the client behaviour.

Though conceptualised differently to psychodynamic perspectives, identifying CT within a cognitive-behavioural context is perceived as being equally constructive to the therapeutic process. Therapists can attend to different aspects of CT which provide distinct but equally valuable information about their clients and therapeutic relationships. In their

clinical writing on addressing CT within supervision, Shafranske and Falender (2008) discuss objective and subjective forms of CT that are complementary to a CBT perspective. They describe subjective CT as a dysfunctional therapist response arising from personal factors (Shafranske and Falender, 2008). Subjective CT is also perceived to reflect therapists' own schemas and beliefs about themselves and others (Cartwright et al., 2014). Though providing less information about the client and less relevance to other therapists, it is critical for therapists to understand and manage their personal reactions to clients, so these do not interfere with decision-making and the working alliance (Cartwright et al., 2014). Conversely, Shafranske and Falender (2008) view objective CT as therapist reactions that occur in response to clients' behaviour, affect and perceptions. A client triggers these responses in other individuals; thus, the therapist's reactions are normative as they are consistent with those of other individuals in the client's life (Newman, 2013; Shafranske & Falender, 2008). Objective CT can therefore provide meaningful information about a client's interpersonal functioning and relationships. Thus, understanding the different components of a CT reaction can provide valuable information about oneself as a therapist, and the interpersonal functioning of a client outside therapy (Haarhoff, 2006).

Identifying, understanding and managing therapist cognitive-affective responses to clients is now considered a fundamental component of CBT (Prasko et al., 2012). In order to support their clients to develop insight into their own thoughts and feelings, CBT therapists need their own foundation of skills for attending to, understanding and expressing their own emotional responses (Beck et al., 2004). In the New Zealand context, where CBT is dominant, there has been an increased focus on the process of self-reflection (Haarhoff et al., 2011). For instance, reflective practice is one of the core competencies for psychologists practising in New Zealand (New Zealand Psychologists Board, 2011). This includes therapists' ability to understand their own personal strengths and weaknesses, emotional and cognitive reactions, beliefs, values and behaviours, and how these affect clients. Though not specific to CT, these processes overlap and address the importance of the role of the therapist in the clinical process.

The following section will examine how CT is conceptualised within family therapy across different therapeutic perspectives, starting with psychodynamic perspectives.

Family Therapy Perspectives of Countertransference

Psychodynamic Perspectives of Countertransference in Family Therapy

The conceptualisation of countertransference in family therapy is continually evolving. Psychodynamic family therapist, Ackerman (1959) disagreed with Freud's approach, which isolated individuals from their families in treatment. Ackerman (1959) believed that the most effective therapy included significant others, so that clients could create a new sense of identity and more meaningful bonds within the family system. Originally trained in psychoanalysis, Ackerman (1959) believed that the well-being of an individual both related to, and resulted from, the condition of the family, and as such, he was instrumental in bringing the theory of family systems therapy into his work. Ackerman (1966) viewed CT as the distorted feelings of the therapist, which occurred in response to the family's transference, the sub-groups within the family, and the therapist's own past. Similar to the classical view, he saw CT as pathological and needing to be resolved in order to benefit the family. However, if an analyst was able to do this, CT became a tool for helping the family (Ackerman, 1966). In Ackerman's view, CT should be included in the treatment of families. However, analysts must be selective about which CT reactions and emotions were injected into treatment, sharing only those that the family needed to experience to become well (Ackerman, 1966).

Other psychodynamic conceptualisations of CT in family therapy have since been proposed. Feld (1982), a psychodynamic family therapist, defined CT as the therapist's perception of the client family as if it were the therapist's own family of origin. Feld (1982) argued that therapists might respond to a member of a family (for instance, the mother, as if she were the therapist's own), a process of communication, or to the family system as a whole. This process occurred on a preconscious level (Feld, 1982). According to Pinsof (1994), a psychoanalytic family therapist and theorist, CT is the emotional bond between therapists and family members. In this view, CT is a normal process in which therapists connect emotionally with key members of a family system (Pinsof, 1994). Pinsof (1994) considered the formation of these emotional bonds and consequently CT to be an active process, in which therapists take interest in, appreciate, and value each individual within a family. Any negative therapist reactions were a consequence of over-connecting or over-identifying with one family member over another and could lead to an imbalance in the therapist's emotional

responsiveness. Pinsof (1994) viewed the absence of CT altogether to be negative for the therapeutic process as it represented a lack of care and connection.

Psychoanalytic and psychodynamic family therapists today recognise the importance of therapists' emotional reactions and view these reactions as essential to the therapeutic process (e.g. Ehrlich, 2001; Flaskas, 1989). Ehrlich (2001), a psychoanalytic family therapist, has written a number of case studies and CT reflections on her family therapy work. According to Ehrlich (2001), CT is the therapists' capacity for involvement in the therapeutic relationship and is key in providing moments of connection with others. Ehrlich (2001) considered her CT reactions, both conscious and unconscious, to be triggered by families' images, memories, words, gestures or tones, which evoked powerful memories and emotional responses. In Ehrlich's view (2001), CT connects and provides information about the inner worlds of both therapists and families. An insight, she argued, is not only crucial to the therapeutic process, but is part of therapists' "lifelong growth in self-understanding" (p. 284).

Family therapist and author Flaskas (1989) played a leading role in incorporating psychoanalytic ideas into the systemic context. She argued for the importance of therapists' contributions to therapy and first talked about the emotional interaction between therapists and families. Flaskas (1989) viewed CT as the involvement of therapists in therapeutic relationships with families including therapists' emotions, attitudes and ways of relating. She argued that reflecting on CT enables therapists to create and protect empathy for families and as such, the term should be borrowed and integrated into family therapy and research (Flaskas, 2005).

Although originating in the context of individual therapy, CT is considered both relevant and important in family therapy. The psychodynamic family therapists mentioned above have all been instrumental in the recognition and use of CT in the family therapy field. The following section examines how family therapists and authors from other theoretical perspectives consider CT within family therapy.

Family Therapy Perspectives of Countertransference

Compared with individual therapy, there has been minimal research and discussion of on the concept of CT in family therapy. This may be due to the opposition to psychoanalytic ideas that family therapists held when family therapy was originally forged and attempting to

differentiate itself as a discipline (Flaskas, 2005; Stratton et al., 1993). Historically, the primary concern of family therapy involved describing behaviour and practical interventions (Flaskas, 1989). Feelings of therapists and families were reserved for adopting specific interventions such as joining or enactment (Flaskas, 1989; Friedlander et al., 2006). It was thought that transference of feelings onto therapists and consequent CT did not occur because the feelings of family members were directed to other family members in the therapy room (Kaslow, 2001). Furthermore, structural and strategic family models viewed therapists as outside the family system in the therapeutic process (Flaskas, 1989), and emotionally neutral from the family system (Feld, 1982). These principles of family therapy are regarded by some as limiting therapists' ability to acknowledge and reflect on feelings within the therapy process (e.g. Flaskas, 1989).

Although family theorists and therapists have been aware of issues relating to CT and have acknowledged problematic reactions from therapists (Friedlander et al., 2006; Stratton et al., 1993), the term CT is not commonly used to describe these processes. This section examines the conceptualisations of processes that occur in family therapy that relate to CT. These conceptualisations indicate that CT and its effects are recognised in family therapy in ways that fit within family therapy principles and techniques. These include suction into the family system, triangulation and split alliances.

System Suction. Suction into the family system is a key concept in structural family therapy developed by leading structural family therapist, Salvador Minuchin and colleagues (Minuchin & Montalvo, 1967). System suction occurs when therapists feel compelled or enticed to join a family system in such a way that the therapists' roles and behaviours become restricted to that shaped by the family system (Minuchin & Montalvo, 1967). For example, a therapist might join a family in the process of avoiding topics or emotions that could lead to emotional outbursts in order to keep the peace within sessions. In this instance, the therapist may feel anxious, based on their own personal fear of conflict or from joining the family's anxiety, which then leads to avoidance behaviours. System suction is thought to limit therapists' objectivity, as they are unable to maintain their role as expert and their distance from families' emotional and interactional patterns (Rait, 1998). Therapists being sucked into families' emotional systems are considered a threat to treatment, as this could result in

maintaining an unhealthy family dynamic or collusion with the family dysfunction (Slipp, 1984).

Triangulation. Triangulation is one of eight key concepts in family systems theory, developed by leading family systems practitioner and author, Murray Bowen (1976). Bowen (1976, 1993) described triangles, or three-person configurations, as the smallest stable relationship system. Triangulation refers to the process in which a third party enters into an emotionally unstable relationship dyad within the system. In family systems therapy, therapists can often enter into emotional triangles. Triangulation can lead to stability in the dyad, as the third party can help in mediating disagreements, offering a fresh perspective, facilitating communication, or providing support (Brown, 1999). In this view, Bowen did not believe the process of triangulation to be dysfunctional; rather it could be a useful therapeutic tool if therapists were aware of the triangulation and remained emotionally neutral, objective, calm and non-reactive (Rait, 1998). For instance, a therapist may knowingly enter into a parent dyad in order to support the effective communication of perspectives. However, triangulation can become problematic if the therapist is caught up in the emotional process of the triangle and lacks insight into it (Winek, 2009). For example, a therapist is inadvertently triangulated when one parent relies on the therapist for communication with the other parent. If unnoticed, triangulation can lead to therapists taking sides, perpetuating the problem, increasing tension or drawing attention away from important issues in a two-person relationship. As a result, the original relationship impasse or dysfunction can remain unresolved. Triangulation can also become problematic if the therapist is pulled into an inappropriate role. Brown (1999) observed that therapists can be pulled into emotional triangles replicating roles previously held by other family members, such as peacemaker, victim, villain or rescuer. Indeed, the negative impacts of triangulation have been documented, with triangulation linked to the impasse and termination of therapy if clients feel they have to choose between the therapist and a family member (Hill et al., 1996).

Split Alliances. In family therapy, therapists attempt to develop an alliance with every family member (Rait, 1998). Friedlander et al. (2011) suggest that CT manifests within family therapy in the form of split or unbalanced alliances. Split alliances occur when a therapist has a stronger alliance with an individual or sub-system within the family compared to other

members or systems (Escudero et al., 2021). For example, a split alliance may occur if a therapist's working relationship with the parents of a family is stronger than their working relationship with the children. In this instance, the therapist may be inadvertently responding to a positive CT reaction to the parents, perhaps because they are reminded of close relationships or individuals from their own past. If the therapist repeatedly aligns with particular family members, other family members can feel alienated or unheard, which threatens the group alliance and jeopardises the treatment (Gehlert et al., 2014). Split alliances may lead to therapist behaviours such as failing to understand each family member's perspective or devaluing the perspective of some family members while reinforcing the perspective of others (Friedlander et al., 2011). As a result, this could perpetuate unhealthy family dynamics and decrease motivation for therapy. Indeed, split or unbalanced alliances tend to predict worse family therapy outcomes (Escudero et al., 2021; Friedlander et al., 2018).

Other Conceptualisations of Countertransference. Other conceptualisations of CT have been proposed within the family therapy field. Rober, family therapist and author, proposed two processes in family therapy which act in a similar manner to CT. Rober (1999, 2010) named these processes the therapist's inner conversation and the therapist experiencing. The therapist's inner conversation refers to the private dialogue that therapists have with themselves during sessions (Rober, 1999). The therapist experiencing refers to the therapists' own experience (including thoughts, feelings and ideas) as a human in the present moment of the session as well as their experience of the client's story (Rober, 2010). Rober (2010) argued that therapists should be sensitive to their own experiencing during therapy as it may be used as a tool to further the therapeutic process if attended to.

Another concept related to CT was proposed by Stratton and colleagues (1993). These family therapists and researchers use the concept of nesting in family therapy, which they proposed as a description of CT in systemic family terms. Nesting builds on the idea that family members have internal models or representations of themselves and other family members, which can be communicated to the therapist (Stratton et al., 1993). The therapist also has their own existing models from their own past, which can be activated by clients. Nesting refers to the complex interaction between these models, which can lead to different reactions in the therapist. For example, a child, whose model of parents is based on love being

associated with unrealistically high expectations, may activate a therapist's own anxious response related to the therapist's self-model of perfectionism and fears of incompetence. According to Stratton et al. (1993), the therapist has to attend to the emotional reaction and consider which internalised model has been activated. If therapists can do this, they can then formulate ideas about how their reaction can be used within family work in ways that are consistent with the systemic approach (Stratton et al., 1993).

Finally, Mojta et al. (2014) discussed self-awareness of internal processes and recognised this as related to CT. Self-awareness of internal processes describes therapists' recognition of immediate and transitory thoughts, emotions, physiological responses, and behaviours during a therapy session (Mojta et al., 2014). Therapists need to understand and manage their own internal processes before they are able to be effective in helping clients gain understanding of their own internal systems (Mojta et al., 2014). Mojta et al. (2014) view this process of gaining understanding of internal processes as a skill, which can be strengthened by therapists.

The examples above demonstrate that while the term CT is generally not used in family therapy, therapists use other language to discuss the processes related to CT. Not only have family therapists been aware of these processes, they have used these to increase their understanding of families and inform the treatment process. The following section further explores the use of CT by family therapists as a source of information.

Countertransference and Understanding the Family. Some family therapists view CT as an important source of information about the client family system (Ehrlich, 2001; Gehlert et al., 2014; Kaslow, 2001; Rober, 2010). It has been argued that CT feelings can provide valuable clinical data about both the internal processes and the interpersonal patterns of families (Kaslow, 2001). For instance, through CT, family therapists can come to understand the alliances that exist in a family, the interactional style and defenses of families, and the ways in which family members perceive and respond to one another (Friedlander et al., 2006). CT that occurs in response to these dynamics is considered an objective CT reaction (Gehlert et al., 2014). Objective CT is a useful source of information to therapists as other people in their clients' lives often share a similar reaction (Gehlert et al., 2014). Family therapists can also reflect on their role or stance in a family and how this may be influenced by the family (Stratton et al., 1993). For instance, Rober (2010) discusses how an emotion may reflect an

invitation by a family to take part in a specific relational scenario, adopt a certain position or play a specific role. Through this in-depth understanding, therapists can gain some insight into family processes and develop detailed information about a family system, including its members, dynamics, rules, boundaries and interpretations (Gehlert et al., 2014). This insight can inform interventions that offer new possibilities for interaction and provide respite from the unhelpful processes (Stratton et al., 1993). Ehrlich (2001) observed in her own practice a considerable amount of what she learned about her client families came from her ability to recognise her own responses to families' verbal and non-verbal behaviour. Thus, if CT reactions can be identified, therapists can use their reactions to a family's interaction patterns to further understand relationships, rules and patterns of behavior within the familial system (Ehrlich, 2001; Friedlander et al., 2006).

Countertransference and Understanding the Self. CT can also be used by therapists to gain insight into the self. Therapists' own material, particularly that which remains unresolved, may lead to CT reactions (Gehlert et al., 2014). These reactions are considered subjective, as other people do not typically share them (Gehlert et al., 2014). Subjective CT occurs when a therapist is triggered by traits of a client family that are similar to the dynamics of their own family, or by a familial relationship similar to a previous one in the therapist's own life (Halperin, 1991). Subjective reactions may also provide therapists with insight into their own values, beliefs and cultural ideas (Gehlert et al., 2014). Although providing less information about the family system, subjective CT is still interpersonal in nature and so can influence the therapeutic relationship and process. For instance, Ehrlich (2001) observed in her own work how her history, even that which she was fully aware of, had affected her communication and behaviour with families.

Summary

In the section above, I have examined the conceptualisations of CT across time and therapeutic perspective, since Freud first introduced the concept in the 1900s. Since then, CT has been recognised and integrated to differing degrees into various theoretical frameworks and therapeutic approaches, including CBT and family therapy. Although processes relating to CT are recognised in family therapy and there is increased use of the term CT, there still appears to be difficulty finding a term for CT that fits for family therapists to describe their

emotional, cognitive or behavioural responses to family clients. Child and adolescent psychiatrist and family therapist, Kraemer (2018) captures this in his writing with, "Because systems therapy saw no use for transference it was thrown out, but countertransference, which is still needed, went with it. I can find no new word for countertransference" (p. 95). Some descriptors and other processes relating to CT do exist within the family therapy field, such as those outlined above, however, an outcome of this conceptual diversity is that theoretical and clinical writings on CT within family therapy appear to remain disconnected.

Therapists' Experiences of Countertransference in Therapy with Adults

This section examines the research and clinical writings on therapists' experiences of CT in individual therapy with adult clients. The research and clinical ideas on CT with adult clients are important to acknowledge, since this is where the majority of CT literature focuses. Moreover, any similarities and differences in therapists' experiences of working with adults versus working with children and families is important in guiding the training and supervision of therapists in these respective fields.

Leading CT researchers, Hayes and colleagues, have made important contributions to our understanding of therapists' experiences of CT when working with individual clients. Hayes et al. (1998) and Hayes et al. (2015) interviewed eight and 18 therapists respectively, about their experiences of CT when working with adult clients. Using Hayes' (1995) organisational framework, the researchers identified common origins, triggers and manifestations of CT responses. The 2015 study further examined therapists' experiences of CT based on therapist reports of successful versus unsuccessful therapy cases. The results revealed a number of consistent primary origins of CT across both studies. These included unresolved personal issues, such as those relating to the therapist's family of origin or partner; and unresolved professional issues, such as doubts about competence and adequacy as a therapist. Similarly, Hayes et al. (2015) identified common triggers of CT. These included (a) the client resembling the therapist or another person in the therapist's life; (b) the content of client material, such as discussing family issues or death; (c) client behaviours, such as dependence or disengagement; (d) client or therapist emotional arousal; (e) client appearance, such as being perceived as attractive by the therapist; and (f) change in therapy

structure, such as clients cancelling, rescheduling or sessions starting late. CT manifested for therapists in different ways across both studies. The manifestations identified were (a) positive or pleasant affective responses (e.g. warmth, caring, compassion, hope); (b) negative or unpleasant affective responses (e.g. anger, envy, guilt, and feelings of inadequacy); (c) behavioural responses (e.g. colluding, avoidance, over involvement or arguing with clients); (d) cognitive responses (e.g. forgetfulness, poor treatment decisions, making assumptions); and (e) somatic responses (e.g. headaches). These responses either facilitated therapeutic processes and outcomes or hindered them, depending on how they were managed by therapists. Both positive and negative feelings toward client seemed to produce such effects (Hayes et al., 2015).

Negative affective responses were examined more closely by Linn-Walton and Pardasani (2014). These researchers examined negative CT responses and therapists' dislike of clients through a series of interviews with five clinicians (two psychologists, two clinical social workers and one emergency room physician). The clinicians in the study identified a number of factors that contributed to or triggered negative CT responses. First, was the client questioning or challenging the therapists' capabilities, or clients requiring therapists to prove their professional expertise and ability to deal with client issues. Second, clinicians experienced negative CT and took a dislike to clients when they felt that clients were not making progress at the pace the therapist wanted, particularly when clients placed the responsibility for fixing the problem onto the therapist. Third was when clinicians felt emotionally insecure or physically unsafe with a client. Clinicians also disliked narcissistic clients, teenagers, clients with personality disorders and clients that had a lack of insight or impaired self-awareness. This study demonstrates that CT occurs across disciplines and professions (Linn-Walton & Pardasani, 2014).

While the above studies used qualitative methods, quantitative methods have also been used to examine therapists' experiences of CT (Berg & Lundh, 2021; Betan et al., 2005). Betan at al. (2005) used the Countertransference Questionnaire, a 79-item clinician-report questionnaire, to explore the cognitive, affective and behavioural responses of 181 psychiatrists and clinical psychologists to individual adult clients. The results revealed eight main types of CT responses: overwhelmed or disorganised, helpless or inadequate, positive, special or over-involved, sexualised, disengaged, parental or protective and criticised or mistreated. Berg and Lundh (2021) similarly used psychometric questionnaires to examine

219 therapists' CT experiences to adult clients. The therapist sample included psychologists, psychiatrists, social workers and nurses from various therapeutic orientations. The results revealed six patterns of CT reactions: over-engaged (e.g. infringing usual limits), disengaged (e.g. distance and boredom), low intensity of CT, high intensity of CT, parental CT (e.g. nurturing, protective, parental toward client), and sexualised CT. For both studies, the CT experiences were independent of clinicians' theoretical orientation, demonstrating that CT experiences occur irrespective of clinical training or therapeutic modality.

Trainee therapists appear to experience additional CT reactions to those outlined above, as shown through two mixed methods studies (Cartwright et al., 2014; Williams et al., 1997). Cartwright et al. (2014) examined 55 trainee clinical psychologists' experience of CT and the triggering client situations. The results of the qualitative analysis revealed a number of themes. First, the trainees wanted to protect or take care of clients. This theme also included therapist feelings of sadness, concern or helplessness. This CT reaction appeared to occur in response to clients the therapists perceived were distressed, traumatised, sad or having difficulties overcoming problems. The second CT theme was psychologists empathising or identifying with client problems, particularly in response to clients who had experienced significant loss, distressing childhood memories or were facing issues similar to the psychologists' own. Third, psychologists felt controlled, intimidated or criticised by clients, which led to them feeling helpless or inadequate. These CT responses occurred in response to clients not making progress or deteriorating, or clients who had difficulty identifying or working towards goals. Other trainee psychologists reported feeling overwhelmed in response to client emotional arousal, disengaged in response to limited client emotional expression, and frustrated or angry in response to client resistance, cynicism or blaming others (Cartwright et al., 2014). Importantly, the results of the quantitative analysis found that the majority of trainees held a level of concern about their CT responses to clients (Cartwright et al., 2014).

These CT reactions and triggers of trainee therapists are consistent with those found previously by Williams et al. (1997). Qualitative analysis revealed that trainees felt anxious-uncomfortable in response to silence, termination issues, cultural differences or worries about their own performance. Trainees felt distracted in sessions in response to their own thoughts, feelings, agendas or treatment planning, and occasionally unengaged or bored. Other negative trainee reports included feeling frustrated-angry in response to perceived

client resistance, and inadequate-unsure-of-self. Positive trainee reports included feeling empathetic-caring towards client sadness or clients they connected with, and feeling comfortable-pleased with clients perceived to be engaged and making progress. (Williams et al., 1997). Trainee therapists also expressed concerns about personal and interpersonal stressors similar to their clients. In response to these reported reactions, supervisors perceived trainees to display negative behaviours, such as avoiding affect or being overinvolved with clients (Williams et al., 1997). However, the quantitative analysis did demonstrate that trainee anxiety decreased over the study length (one semester).

Managing Countertransference in Therapy with Adults

This section examines the research and clinical writings on the CT management for therapists working with individual adult clients. Even though therapists can experience many types of CT reactions, such as those outlined above, these reactions do not always lead to CT behaviours. It is important to distinguish between experiencing CT and engaging in CT behaviours, also known as CT enactment (Robbins & Jolkovski, 1987). The frequency with which therapists engage in CT behaviours is lower than the frequency of experiencing CT reactions (Hayes, 2004). This suggests that therapists can experience and manage their CT without acting on it (Cartwright & Gibson, 2015). Some authors have suggested that the management of CT reactions is more important than the occurrence of the reactions themselves, and the way in which the reaction is managed by therapists is critical to therapy outcomes (e.g., Shafranske & Falender, 2008). Gehlert et al. (2014) define successful management of CT as "the avoidance of adverse effects on the clinical encounter, and capturing the benefits of understanding the reaction" (p. 13). Effective management strategies therefore help therapists regulate and use their CT reactions productively (Hayes et al., 1998), without the CT negatively influencing therapist behaviour (Robbins & Jolkovski, 1987). These management strategies are important as even minimal CT enactment can have significant adverse effects on the therapy outcomes if not dealt with effectively (Hayes, 2004).

The study discussed above by Hayes et al. (2015) concluded that both successful and unsuccessful therapy cases, as reported by therapists, differed markedly in therapists' efforts and ability to manage their CT. From therapist reports of successful therapy cases, the

research suggested strategies for the effective management of CT. This involved remaining attentive to internal processes and experiences during therapy sessions, internal reminders to oneself during therapy to stay calm, remaining attentive to the client and remaining objective, using self-care effectively outside of sessions, and continually reflecting on treatment and consulting with other people. Remaining attentive to internal processes is particularly important for therapists. Greater self-awareness of internal experiences will reduce the degree to which internal reactions leak out into overt CT behaviour, which is more likely to affect clients (Hayes & Gelso, 2001). Indeed, research has shown that therapists who are more aware of CT experiences will engage in less CT enactment, such as avoidance, emotional distancing and withdrawing from client (Latts & Gelso, 1995; Robbins & Jolkovski, 1987).

Mojta et al. (2014) conducted interviews with seven therapists to examine whether new therapists can gain awareness of their internal processes and whether this awareness influences clinical work. The results suggested that therapists can be supported to understand and manage their own internal systems, and that increased therapist awareness of their own internal processes has beneficial effects on therapeutic relationships and outcomes. These effects included enhanced therapeutic relationships, increased client awareness of their own internal processes through role-modelling, and increased therapist understanding of clients' internal processes. Additionally, therapists were able to recognise when their needs were overtaking those of their clients and preventing the therapy from progressing.

In addition to self-awareness, therapist self-integration is suggested as an important preventative and management strategy for CT. Self-integration refers to the degree to which therapists' personal conflicts are resolved (Hayes & Gelso, 2001). As such, it is proposed that greater resolution of therapists' personal issues or past conflicts not only reduces the probably that CT occurs, but also puts the therapist in a better position to make use of their own experiences to manage the CT and benefit the client (Hayes, 2004; Hayes & Gelso, 2001). In fact, research has found that self-integrated therapists typically have fewer CT reactions and more positive therapy outcomes (Gelso et al., 2002). This implies that personal therapy may be useful for therapists to identify and work through their own pasts. Indeed, personal therapy is important to managing CT, particularly chronic or repetitive CT (Hayes et al., 2018). This suggestion was first made by Freud (1958, as cited in Dubé & Normandin, 1999), and has been incorporated into psychotherapy training. Winnicott (1949) also referred to the

importance of personal therapy stating that the "analyst needs to be himself analysed" (p. 69) in order to become free from unconscious past conflicts and avoid acting on his or her own feelings. Personal therapy assists with resolving major past conflicts so that these are less likely to occur in clinical work and affect the therapeutic process.

Other research into the effective management of CT for therapists has explored the role of meditation. Fatter and Hayes (2013) used reports of 100 trainee therapists and their supervisors to examine the relationship between meditation experience and CT management. The results found that the meditation experience of therapists is positively associated with their supervisors' ratings of their CT management ability, suggesting a behavioural strategy through which therapists might develop their CT management skills. The authors suggested that meditation can help therapists to be more present, manage their anxiety better and increase awareness of their thoughts and feelings.

Cartwright et al. (2016) developed a trans-theoretical training designed to make CT more accessible to developing therapists in CBT dominant programmes. The training included three components. The first component aimed to increase trainee's awareness of CT thoughts and feelings. This was done by talking about CT experiences of other therapists, including trainees and experienced clinicians, as well as the definitions of CT from different therapeutic perspectives. Second, trainees were introduced to the ideas of subjective and objective CT, and that CT can be a valuable source of information about the client's experience. Case examples and class discussions were used to support this understanding. Finally, the last component aimed to develop trainee therapists' ability to manage CT, through the teaching of different strategies. These strategies included calming techniques (breathing, mindfulness and calming self-talk) and forming an empathetic view of the client. This training helped developing therapists understand the concept of CT further, enabling them to become more aware of their CT reactions and reflect on these. Developing therapists felt able to manage CT more effectively and integrate the theory into their professional practice. Additionally, the training helped to normalise and validate CT reactions for both trainees and academic staff, and provided a framework to consider CT (Cartwright et al., 2018).

Leading practitioner authors have suggested other management techniques based on their own clinical work and experiences. For instance, Shafranske & Falende (2008), clinical supervisors, discuss the importance of supervision for therapists in managing CT. Supervision provides the space for therapists to explore their personal reactions in therapeutic settings,

and the impacts these can have on the therapeutic process. These include therapists' interactions with clients, their expectations, and professional conduct. Effective supervision helps therapists understand how their identities, assumptions, previous experiences, perspectives and culture influence their professional work and their clinical understanding of clients (Shafranske & Falender, 2008). By increasing awareness of CT through supervision, therapists can process CT reactions, protect the therapeutic relationship from CT enactment and engage clients in a meaningful therapeutic process (Cartwright, 2011). However, the benefits of supervision for CT depend on the quality of the supervisory working alliance (Bucky et al., 2010) and the openness to explore personal factors related to CT. Shafranske & Falender (2008) emphasise that the supervisor should highlight the normative nature of CT and use personal disclosure to encourage openness and to role model how to discuss CT.

Facilitating CBT therapists' ability to reflect on their own contribution and response to the interpersonal processes has become an increasingly important part of training competent cognitive-behavioural therapists (Haarhoff, 2006). However, due to the relative recency of CT within CBT, many of these remain as clinical ideas and are yet to be empirically tested to explore their effects on treatment outcomes. CT management strategies within CBT are based on CBT principles and techniques, though they share similar goals to those of CT management in psychotherapy. Notably, this is to increase therapist self-awareness. In CBT, this is achieved through therapists developing insight into underlying schemas, core beliefs and automatic thoughts in response to the therapeutic relationship (Haarhoff, 2006). This may include completing questionnaires and practicing CBT techniques and interventions on oneself. Questionnaires such as the Therapists' Schema Questionnaire (Leahy, 2008) can assist in identifying underlying schemas, which once identified can be monitored and managed in therapy and supervision. CBT techniques that can be utilised by the therapist on oneself include mood diaries or thought records relating to therapy sessions, or completing a personal functional analysis using the five-part model of CBT (Haarhoff, 2006).

Existing research into CT with individual adult clients indicates that therapists can experience a range of CT reactions towards individual clients, and that there are a number of strategies available to therapists to manage these responses. It is important for therapists to be aware of and utilise these CT management strategies, to prevent CT enactment occurring and adversely affecting the therapeutic relationship and treatment outcomes. The next

section of the chapter will outline the CT experiences and management strategies of therapists working with children and families.

Countertransference in Therapy with Children and Families

This section examines therapists' experiences of CT when working therapeutically with children and families. First, it considers some of the additional challenges faced by therapists working with children and families, including the increased number and strength of reactions, as well as the further difficulties in managing these. Following this, the section will explore the literature on therapists' CT experiences, followed by strategies recommended to manage these reactions.

Some authors argue that CT reactions are more frequent and stronger within child and family therapy compared to adult therapy (e.g. Gabel & Bemporad, 1994; Kohrman et al., 1971; Friedlander et al., 2006). This has been suggested based on a number of reasons. First, discussing family issues is more likely to produce therapist CT reactions within individual therapy (Hayes et al., 1998) and in family work when these family issues are played out in real time in the presence of a therapist (Friedlander et al., 2006). Second, if unresolved conflicts laid down in childhood are a potential source of CT reactions, then working directly with family dynamics may be more likely to trigger therapists' own unconscious childhood conflicts (Friedlander et al., 2006). Family therapy is also thought to be more saturated with immediate emotions, which can be different for each member of the family (Rober, 2010). There are also more individuals and relationships that can activate therapist emotions, including each member and sub-system of the family, as well as the family system as a whole (Gehlert et al., 2014). Stronger CT reactions to children are likely to be the result of child characteristics such as their directness, primitiveness and use of behaviour to communicate rather than verbal language (Gil & Rubin, 2005; Kohrman et al., 1971). Furthermore, children's greater demand for immediate gratification, their highly charged emotions and their unpredictability can force therapists to be more actively involved in the process, which can hinder their capacity to self-monitor their reactions (Dubé & Normandin, 1999).

Additionally, CT reactions can be harder to successfully identify and manage in family therapy due to the complexity of the environment compared to individual therapy (Gehlert

et al., 2014). This is because family therapists must attempt to maintain more alliances, involving each member of the family on an individual level, the sub-systems of the family and with the family unit on a group level (Friedlander et al., 2011; Rait, 1998). Moreover, therapists also respond to and must attempt to manage the within-family alliance, which refers to the family members' thoughts, feeling and behaviours towards one another (Friedlander et al., 2011). These complex alliances may affect therapists' ability to manage their responses.

Therapists' Countertransference Experiences in Therapy with Children and Families

There is minimal empirical research on the CT experiences of therapists working with children and families. A literature search of the term countertransference and other possible terms (therapist emotions, emotional responses, emotional reactions, therapist attitudes, therapist experiences, therapist reactions) found only two studies that investigated CT experiences of therapists who worked with families (Aradas et al., 2019; Hay et al., 2019). The search revealed just four studies that investigated the CT experiences of therapists working with children or adolescents (Shevade et al., 2011; Ulberg et al., 2013) which included two doctoral theses (Biggs, 2003; Ingley-Cook, 2019). Other recent reviews of the empirical literature do not include any research into CT when working with families (Hayes et al., 2018) while other studies have excluded the experiences of family-oriented therapists (Berg & Lundh, 2021). The available literature on CT with children and families largely consists of theoretical understandings and clinical writings by experienced family therapists (e.g., Karver et al., 2005) or personal case studies and vignettes (e.g., Ehrlich, 2001; Jacobs, 1993). This next section examines the research studies that have been conducted, followed by a discussion of clinical and theoretical writings.

Hay et al. (2019) conducted an anonymous online questionnaire with 22 psychologists in New Zealand (12 clinical and 10 trainee) about their experiences of CT when working with children and families. Four main themes emerged from the analysis. The first theme was reports of psychologists feeling empathetic towards the child or adolescent, and experiencing an urge to protect them. This often occurred alongside CT feelings of anger or frustration towards parents who were perceived to lack understanding about the impact of their behavior on the children. Second, psychologists reported feeling frustrated or helpless with

challenging clients, such as those displaying confrontational, destructive or disengaged behaviour. The third CT theme to emerge was psychologist reports of feeling worried or afraid of clients, or worried for them in response to clients' threatening, intimidating or angry behaviour. Finally, some therapists reported positive CT responses, including feelings of compassion, affection or identification with clients. The therapists reported this reaction when they had a strong therapeutic relationship or when they were reminded of their own experiences and identified with clients. The majority of therapists reported experiencing their CT reactions often in child and family therapy (Hay et al., 2019), indicating that the described reactions are a common occurrence.

While Hay et al. (2019) asked participants to report on CT in non-specific child and family work, Aradas et al. (2019) focused specifically on nine family therapists' experiences of delivering family-based therapy for anorexia nervosa (FBT-AN) in adolescents, a condition which is life-threatening. One of the themes to emerge from family therapist narratives was feeling responsible and blaming themselves when the adolescent did not progress to weight restoration or the intervention did not work. At this point, some therapists felt their role was burdensome rather than useful, leading to self-doubt and feelings of incompetency. One therapist struggled with the distress of an adolescent and their family, which reduced the therapist's sense of agency, increased her own feelings of distress and led to her decision to cease practising this form of therapy.

Ulberg et al. (2013) similarly examined therapists' emotional reactions towards adolescents, however with diverse mental health presentations. The researchers used a self-report questionnaire comprising 24 feeling words in order to examine 50 therapists' responses. The results reveal four overarching emotional experiences of therapists. These were confident (e.g. feeling enthusiastic, happy or warm), inadequate (e.g. feeling overwhelmed, tense or helpless), disengaged (e.g. feeling irritated, cold or indifferent) and neutral (Ulberg et al., 2013). The researchers did not explore the association of these CT experiences to adolescent characteristics, presentations or content; rather they explored them in relation to therapist characteristics. For instance, increased levels of confident CT relate to greater years of experience, increased amounts of supervision and a stronger working alliance (Ulberg et al., 2013). The authors concluded that these four broad feelings represented meaningful and discrete emotional reactions of therapists.

Three studies, including two doctoral theses, investigated the CT experiences of therapists who worked with traumatised children (Biggs, 2003; Ingley-Cook, 2019; Shevade et al., 2011). Biggs (2003) interviewed 12 therapists who treated abused and neglected children as part of her doctoral thesis. The results revealed a number of CT themes. Most notably, it emerged that the majority of therapists experienced both positive and negative CT reactions to their child clients. Positive CT feelings included maternal feelings of wanting to care for and protect children. This included therapists wanting to save the child or take them home with them, particularly in response to neglect. Negative CT feelings commonly involved feelings of anger and incompetence towards children whose behaviour escalated, or feelings of anger occurring for children who were limited in their ability to emotionally or verbally express themselves. Other CT themes included feelings of anxiety and helplessness, frustration and powerlessness, and sadness.

Ingley-Cook (2019) also interviewed 12 therapists in New Zealand working with children who had experienced sexual, physical or emotional abuse and/or neglect as part of her doctoral thesis. Ingley-Cook (2019) found that therapists experienced five types of CT reactions when working with traumatised children: anger, fear, care, helplessness and disconnection. Anger occurred in response to children displaying challenging behaviours, decisions being made by parents or the organisation about the child that therapists did not agree with, and in response to the wider systems around the child. Therapists felt fear in response to anxious children, risk-taking behaviours and conflictual or critical parents. Therapists had CT experiences of wanting to take care of children after hearing about their negative early experiences, and helplessness or incompetency in response to challenges with children and their parents. Finally, some therapists felt disconnected from children, and experienced emotions such as boredom, dislike or emptiness, which therapists perceived to be a reflection of the child's emotions. The majority of therapists saw their CT as primarily triggered by the behavioural and emotional presentation of the child and interactions with the child's parents, suggesting that these CT reactions are likely to occur for therapists working with this client group.

The final study to explore therapists' CT in response to traumatised children was conducted by Shevade et al. (2011). These researchers interviewed nine therapists regarding their responses to children displaying sexually problematic behaviour. They found that therapists from various therapeutic approaches experienced powerful reactions to working

with this client group, including powerlessness, incompetence, discomfort, shock and sadness. In response to systems or networks around the children, therapists often felt considerable anxiety and fear. Some of the participant therapists also reported feeling like an abuser or a victim themselves, feelings that are difficult for therapists to admit due to the perceived implications that this may have for themselves (Shevade et al., 2011). Finally, a unique CT manifestation found by Shevade et al. (2011) was therapist reports of physical reactions, such as feeling fluttery, sick or jittery. The authors propose that these physiological responses occur with children that have been abused because the trauma experienced by children is at a non-verbal, bodily level. Therefore, bodily reactions of therapists can provide important information about what the child may be experiencing (Shevade et al., 2011).

Clinical writings on CT in families in which sexual abuse has occurred suggest similar reactions. Shay (1992) noted the presence of rescue fantasies, sadness, disbelief, anger, confusion, guilt, shame and revulsion in response to working with child sexual abuse. Other reactions may include rage at the perpetrator, identification with the perpetrator, fear and sexual feelings. Shay (1992) argued that some of these reactions may be similar to those experienced by clients and their families, providing a window into their own affective state. Similarly, McElroy and McElroy (1991) observed that therapists often experience feelings of inadequacy, frustration, helplessness, anger and blame, and the desire to rescue the child in the therapeutic treatment of sexual abuse families. Carr (1989) grouped CT reactions to families in which abuse has occurred into five categories, based on observations made of therapists. These were rescuing the child, rescuing the parents, rescuing the mother and child while persecuting the father, rescuing the father, and persecuting the family.

Clinical observations suggest CT experiences can also occur when working with families undergoing significant family transitions such as divorce and re-marriage (Springer, 1991; Wallerstein, 1990). These include anger in response to perceived inappropriate, immoral, immature or aggressive behaviour between parents, such as lying, threats or manipulations. Family therapists have also observed a wish to rescue children of divorcing parents when the child or adolescent is exposed to or forced to participate in the parental misconduct (Springer, 1991). Wallerstein (1990) conducted extensive research on the impact of divorce on children, and reports a number of CT reactions based on her observations of working with divorcing families. CT reactions of love, hate, sexual jealousy, anxiety and fear of loneliness have been recorded as common responses of therapists working with divorcing

parents, alongside rage and anger in response to perceived diminished parenting and fearful or grieving children (Wallerstein, 1990).

Other therapists observed CT within psychoanalytic and psychodynamic family therapy with children (Scholfield-MacNab, 1989) and between parents and infants (Bonino & Ball, 2013). Using six clinical vignettes of parent-infant therapy, Bonino & Ball (2013) observed CT reactions of emptiness and abandonment in response to grieving or depressed mothers, feelings of being overwhelmed in response to disorganised or aggressive mothers, and feelings of inadequacy and a compulsion to take over and solve the problem in cases of high parental anxiety. Scholfield-MacNab (1989) suggested a primary CT experience of wanting to protect children, which may lead to CT enactment such as excluding children from sessions or avoiding emotions in sessions. Bonovitz (2009) in a case study of his psychotherapeutic work with a child, noted that therapists can experience the same range of affect in response to children as to adults, including love, hate, boredom, affection, contempt, tenderness, guilt, excitement, and annoyance. However, feelings of responsibility and protectiveness may occur more with children, as well as the greater presence of therapists' own childhood memories and contact with their child self (Bonovitz, 2009).

Finally, theoretical writings, such as those of Gabel and Bemporad (1994) and Kohrman et al. (1971) suggested some CT experiences for child and family therapists based on their observations of research and practice. Gabel and Bemporad (1994), family therapists, proposed that therapists can experience CT if a child triggers a therapist's own memories or unresolved conflicts. This can potentially lead to CT enactment in which the therapist reacts to the child's parents as if they were the therapists' own parents. Alternatively, if therapists over-identify with a child, this could result in encouragement, advocacy, or anger directed at the parents. They also believed that child and family therapists could feel competitive with parents, and might want the child to respect or admire the therapist more than the parent. Kohrman et al. (1971), practitioner authors, suggested that CT reactions originate from child therapists' own longings from childhood, and can emerge for the therapist as defensiveness and overly strict adherence to rules, or permissiveness and letting anything go in therapy. They also suggested a rescue fantasy occurring for child therapists when they identify with a child or parent or experience positive CT toward a child.

The research and clinical literature has suggested a diverse range of strong CT reactions that occur for therapists in their therapeutic work with children and families. To

help therapists notice their reactions, Halperin (1991) outlined a number of clues to the presence of CT in family therapy. The first of these is the intensity of therapist feelings. If the intensity of the feeling is out of proportion to that of the situation, CT may be occurring. Second, unusual or out of character behaviour by the therapist may be a reflection of underlying CT. Third, feelings of guilt may signify a deeper process such as CT. CT is also considered to occur when empathy for a client progresses to identification with that client (Gabel & Bemporad, 1994). The following section outlines the strategies that therapists can use to manage their reactions once therapists have been alerted to CT occurring.

Managing Countertransference in Therapy with Children and Families

The family therapy field offers limited research on the ways in which therapists manage their CT reactions in therapeutic work with children and families (Rober, 2010). Many of the proposed management techniques are drawn from practitioner experiences (e.g. Halperin, 1991), observations (e.g. Rober, 2010) and theoretical writings (e.g. Gehlert et al., 2014; Guest & Carlson, 2019). Research on the management of CT with children and families is outlined first, followed by a discussion of clinical and theoretical writings.

Strategies for the management of CT within therapy sessions are suggested based on previous research of therapists' experience working with children and families (Hay et al., 2019) and traumatised children (Ingely-Cook, 2019; Shevade et al., 2011). Therapists in these studies reported strategies to calm and center themselves in sessions, such as pausing, taking deep breaths, presenting a calm demeanor to clients, letting go of difficult feelings and attempting to move into a more balanced emotional state (Hay et al., 2019). Additionally, self-soothing inner dialogues, a sense of humour, drawing, and writing were identified by therapists as constructive management strategies for CT within sessions (Shevade et al., 2011). Sharing CT feelings with families or using CT as a basis for responses is thought by some therapists to be useful both for themselves and their client families if this seems appropriate to the family and session (Hay et al., 2019). This strategy may demonstrate empathy and interest in the family's perspective, and help children learn how to express their own inner experiences (Hay et al., 2019; Ingley-Cook, 2019).

Outside therapy sessions, utilising personal and professional resources and support has been identified as an important management strategy for CT by therapists (Hay et al.,

2019; Ingely-Cook, 2019; Shevade et al., 2011). Therapists in these studies reported that attending individual and group supervision, team meetings and talking about reactions with colleagues is critical for reflecting on and processing CT. While therapists may not speak about the work directly to family and friends, these personal relationships can support therapists to manage the emotional impact of the work and help identify when work is taking a toll or leading to burnout (Ingely-Cook, 2019). Additionally, practising self-care can assist with the management of CT and personal well-being of therapists who work with children (Ingley-Cook, 2019). These strategies include sleep hygiene and management, healthy eating, playing or listening to music and reading, as well as physical based self-care practices such as going to the gym, yoga and running (Ingley-Cook, 2019; Shevade et al., 2011). Therapists also need to draw a boundary between their personal and professional lives by avoiding work at home, leaving work on time, and having a balanced caseload to facilitate the management of CT and the impact of the work (Ingley-Cook, 2019; Shevade et al., 2011).

As with adult research, identifying CT reactions and self-awareness are critical for the management of CT when working with children and families (Hay et al., 2019; Shevade et al., 2011). If therapists are able to notice and acknowledge their CT, they can use this reaction as source of understanding about their clients and themselves, and manage the effects of the reaction. Many therapists in these studies thought that personal therapy helped increase their self-awareness (Shevade et al., 2011) by understanding their own processes and vulnerabilities which in turn enabled them to process CT more effectively (Ingley-Cook, 2019). Indeed, personal therapy has been shown to help therapists more effectively manage CT and enhance therapeutic efficacy with children and families (Dubé & Normandin, 1999). In their study on the effects of personal therapy on the reflective ability of trainees in child and adolescent psychotherapy, Dubé and Normandin (1999) examined reactive versus reflective mental activity in response to case vignettes. The results revealed that trainees who had undergone their own personal therapy were equally reactive to those who had not had therapy. That is, they had the same amount of initial affective reactions to the children in the vignettes. However, those trainees who had undergone personal therapy were less likely to act on their first affective reaction, and more likely to produce more elaborate formulations. This study suggests that although personal therapy does not reduce affective responses, it enables trainee therapists to be less reactive to them and develop a richer understanding of their clients.

Family therapist supervisor, Halperin (1991), observed and discussed the importance of personal therapy while working with children and families in her clinical writings. She suggested that therapists' awareness of their own areas of vulnerabilities when working with families is the best way to identify, manage and prevent CT interfering with therapy (Halperin, 1991). Personal therapy is particularly important when therapists experience persistent and repetitive CT reactions with the families they are working with or when a therapist experiences a strong subjective CT reaction. However, she also suggested it is important for therapists to have personal therapy prior to starting work with children and families, so that therapists are aware of their own personal issues during clinical work. As stated by Feld (1982), "every family therapist who has not been in treatment himself, inevitably goes into family sessions with partially unresolved and preconscious problems having to do with his family of origin" (p. 7).

Therapists working with children and families need constant awareness and attention to self (Kohrman et al., 1971). If therapists are aware of and acknowledge their CT, Halperin (1991) suggested some strategies that therapists can use in order to manage their reaction further. First, Halperin (1991) advised therapists to "disengage from the enmeshment" (p.137) and restore personal boundaries. This can be done by taking deep breaths, asking questions, talking to a family member that the CT is not in response to, being silent, or leaving the room if necessary. These strategies are designed to help therapists take a moment of reflection on what might be happening and why they may be reacting in a certain way. If, through reflection, a therapist is able to identify that they are experiencing objective CT, Halperin (1991) goes on to suggest that the therapist may then use their reaction to understand what the family is trying to tell the therapist through the CT, and how this informs the experiences or interactions of family members. On the other hand, if a therapist identifies their CT as subjective and as acting inappropriately, Halperin (1991) advises the family therapist to acknowledge their behaviour. This is important for role modelling honesty and increasing trust in the therapeutic relationship. Other authors have suggested that therapists should share CT feelings openly with client families (Lantz, 1993; Scholfield-MacNab, 1989; Whitaker et al., 1965). This can make it less likely that CT feelings will be acted upon and avoids their potential destructiveness (Whitaker et al., 1965). Moreover, sharing CT experiences of being with the family could help the family reflect upon itself and its own patterns, thereby facilitating change and growth in the family system (Lantz, 1993).

It may not always be possible for therapists to understand the complexity of the CT within a session, therefore further reflection outside of the session may be required (Rober, 2010). This can be done by thinking, writing or talking with colleagues about the session and what the therapist experienced. Rober (2010), based on his reflections of clinical cases, proposed two concepts that may help therapists reflect on their experience during a session. These are invitation to act, whereby the therapist considers how their emotion might be inviting them to play a particular role in the family and the potential positive or negative effects of this role; and opportunity to dialogue, whereby the therapist reflects on how the emotion can be introduced into the dialogue in a useful and constructive way. As a result of these reflections, a "renewed curiosity can develop in the therapist, leading to a fresh empathic connection with the family members and reopening space for rich and surprising dialogues" (Rober, 2010, p. 12).

Reflection on CT may continue with clinical supervisors. The importance of clinical supervision for managing CT is discussed in the clinical writings of family therapy supervisors (Gehlert et al., 2014; Halperin, 1991). Supervision plays an important role in bringing therapists' awareness to the impact that their CT reactions have on their encounters with families, and is key to therapists' ability to utilise CT (Gehlert et al., 2014). As with adult work, supervision for therapists working with families is critical to changing problematic CT reactions into therapeutically useful ones, as they provide the therapist with insight into the family members, relationships, rules, boundaries and dynamics (Halperin, 1991). The ongoing discussion and exploration of CT within supervision will help therapists recognise their CT and develop their ability to analyse their reactions, including the origin, trigger and impact of a response. Only when therapists recognise and analyse their reactions can they make use of them in beneficial ways (Gehlert et al., 2014). Without supervision to help process CT reactions, work can be left unprocessed for therapists and increase the likelihood that they will act on their CT behaviours (Halperin, 1991).

Guest & Carlson (2009) proposed a rationale for using mindfulness strategies to manage negative CT when working with children who exhibit externalised behaviours, a presentation that can be challenging for therapists. The authors suggested that due to the stressful nature of these behaviours, therapists can become activated physiologically, which may lead to negative CT such as anger and frustration and CT enactment. They suggested that mindfulness can mediate therapists' ability to be influenced by a child's behaviour through

increasing awareness of body sensations and breathing. Mindfulness facilitates therapists' ability to emotionally regulate, which in turn enables them to be non-reactive and present (Guest & Carlson, 2009). The authors proposed that the more non-reactive a therapist is, the better able they are to manage their CT reactions and respond with genuineness and unconditional positive regard. These are the most important characteristics to the therapeutic relationship when working with children, and are the primary elements of change (Landreth, 2012).

Finally, Gil and Rubin (2005) suggested that addressing and resolving CT for therapists who work with children could use the same modality as that used in therapy, notably play, art, and sand therapy. While much of the existing literature focuses on verbal management techniques, such as reflection, supervision and personal therapy, the authors proposed that verbal strategies for addressing CT may not be optimal for therapists using more non-verbal therapeutic techniques. Instead, they recommended that therapists can use CT play, art, sand, role-playing and storytelling to understand and resolve CT. This form of management may be a more time consuming and vulnerable process for therapists; as such, it may be an additional form of processing beyond the verbal means already discussed or with particularly strong CT reactions. Managing CT is a skill that therapists continue to develop over their careers with increasing levels of experience and awareness of themselves. This is summed up by Ehrlich (2001), concluding his reflections on CT in family therapy:

> Whether with a couple, a family, or a patient on the couch, all we have is the present instant. Either we act, or do not act; speak, or do not speak. However certain we feel when we do speak, the consequences will not be known until later, sometimes much later, or not at all. And whatever we do learn will only be partially understood. So we listen, learn, modify, sometimes apologize for our mistakes, and keep trying to get it right (p. 295).

The literature overwhelmingly supports the importance of awareness and management of CT in therapeutic work with children and families. It is therefore important to address this gap in research, so that therapists are in the best position to manage any effects of CT and clients are in the best position to benefit therapeutically.

The Current Study

Research and experienced therapists highlight the inevitable nature of countertransference across therapeutic perspectives and modalities. CT research is essential because therapists' personal reactions and the way in which these reactions manifest and are managed are crucial to therapy processes and outcomes. However, there is a lack of empirical research into the CT experiences of therapists working with children and families, despite suggestions that CT reactions are common when working with children and families, with some researchers suggesting reactions are more intense in comparison with working with individual adult clients (Dubé & Normandin, 1999; Gabel & Bemporad, 1994).

The purpose of this study was to address some of these gaps in the research. This thesis study aimed to contribute to the understanding of the child and/or family behaviours, therapist sensitivities and therapy situations that trigger countertransference in therapists working with children and families. It also aimed to understand the nature of CT reactions associated with these triggers. Additionally, it aimed to explore how therapists understand and manage CT, as well as the perceived impacts of CT on clients, therapists and the therapeutic relationship. The research questions for the current study were:

1. How do therapists working with children and families conceptualise countertransference?
2. What are the triggers of countertransference in child and family therapy, and what are the nature of these reactions?
3. What strategies do therapists use to manage their countertransference reactions when working with children and families?
4. What effects do therapists perceive countertransference to have for clients, themselves and the therapeutic relationship?

The current study therefore has important implications for training, supervision and support of therapists working with children and families.

Chapter Two – Methodology

This study investigated therapists' experiences of CT when working with children and families. It aimed to develop an in-depth understanding of the emotional and behavioural responses of therapists working with children and families, and therapists' understanding of what triggers these responses. It also explores therapists' conceptualisations of CT, the therapeutic impacts of CT, and the strategies therapists use to manage their reactions. The study uses qualitative data collected from fourteen interviews with therapists (psychologists, psychotherapists and psychiatrists) from around New Zealand. Therapists were interviewed individually using a semi-structured interview.

This chapter outlines the qualitative methodology used in this study, including the assumptions and characteristics of qualitative research and the steps taken to ensure the overall quality of the study. The method of this study is then presented, including recruitment, participant information, and data collection and analysis.

The Qualitative Approach of this Study

Qualitative research has largely developed in response to the recognition of diverse social contexts and perspectives that can be difficult to capture using traditional quantitative methodologies (Flick, 2009). Within social research, traditional quantitative methods are thought to be limited in their ability to describe the human experience, as the methods lack context and meaning (Flick, 2009). In contrast, qualitative research can show researchers how people interpret and make sense of their experiences within the context of their social and cultural environment (Flick, 2009; Merriam, 2002). Qualitative methods are often exploratory, search for the meaning of experiences, and seek to generate new ways of understanding phenomena deeply.

Qualitative research is often influenced by constructivist assumptions, distinguishing it from the positivist assumptions that are typical of quantitative research (Krauss, 2005; Merriam, 2002). Constructivist views hold that there are multiple realities constructed by people with different experiences and perspectives, that knowledge is obtained through understanding the meaning attached to the phenomena, and that this knowledge is context and time dependent (Krauss, 2005). In qualitative research, context is the key to

understanding phenomena, and thus the best way to explore it is to become immersed in it (Krauss, 2005). A qualitative approach is therefore used in this study as its purpose is to explore the ways in which therapists understand their experiences of countertransference and attach meaning to them.

Characteristics of Qualitative Research

There are several key characteristics of qualitative research. Firstly, qualitative research focuses primarily on meaning, and understanding how people make sense of their experiences within their particular contexts (Atieno, 2009). Qualitative research can provide an in-depth understanding of the experiences of the phenomena being studied (Merriam, 2002). Secondly, the primary instruments for the collection and analysis of qualitative data are the researchers themselves (Merriam, 2002). This promotes an in-depth understanding, as the researcher can be flexible, responsive and adaptive to the participants and the research setting. It also allows for the exploration of unexpected avenues of the data (Croker, 2009), for example, the researcher can use nonverbal information, check the accuracy of information, summarise and clarify, and begin to interpret the data immediately (Atieno, 2009; Merriam, 2002). Thirdly, qualitative research is descriptive, in that the meaning and understanding of the data is gained and expressed through words and/or images. This description aims to be vivid and rich, and capture the complexities of the human experience (Rolfe, 2006). Finally, while qualitative research can be used in response to most research questions and answer deductive hypotheses, the process of qualitative research is largely inductive and exploratory (Atieno, 2009). This means that the researcher builds concepts and ideas or theories from the data, and observations and understandings of the details. Due to the complexity and in-depth nature of qualitative research, a small and selective research sample is often used.

Situating the Research

A number of qualitative approaches have been developed over time. Although they share key characteristics, they are based on different philosophical assumptions (Merriam, 2002). According to Merriam (2002), there are three main qualitative approaches. First is the interpretive perspective, which is used to seek an understanding of the meaning constructed

by individuals based on their interaction with the world at a particular point in time. Second is the critical perspective, which is used to expand on the interpretive position to explore how the social and political contexts have shaped the individual's constructed reality. Finally, a postmodern approach is used to deconstruct the idea of reality even further, by asking what it is and how it is organised (Merriam, 2002).

This research study utilises an interpretive perspective, as its goal is to form an understanding of the participants' experiences reality, rather than emancipate or deconstruct it (Merriam, 2002). The interpretive approach enables an open-ended and contextualised perspective that is sensitive to time, place and situation (Creswell & Miller, 2000). Specifically, by adopting an interpretive study design, this study goes beyond describing and summarising the data to exploring underlying ideas and assumptions that are seen to shape the content of the data (Braun & Clarke, 2006). The study design exemplifies all of the fundamental characteristics of qualitative research and the interpretive approach is used to gain insight into therapists' experiences of CT, how they understand it, and their perceptions of how CT affects them, the therapeutic relationship, and therapy outcomes. Furthermore, the data and meaning are mediated through myself, the primary researcher, along with the review process to be described later, and the data outcome will be descriptive.

Evaluating Qualitative Research

Trustworthiness and authenticity have been proposed as useful and appropriate criteria for evaluating qualitative research (Lincoln & Guba, 1986). Trustworthiness refers to the credibility, dependability, and confirmability of research procedures and findings, while authenticity describes the ability of research to be fair, lead to improved understanding and motivate action of others (Creswell & Miller, 2000).

A number of strategies have been proposed to ensure the trustworthiness and authenticity of qualitative research findings (Lincoln & Guba, 1986; Noble & Smith, 2015). Primarily, this is accounting for the personal bias and worldview of the researcher within the research findings (Atieno, 2009). The researcher's subjective contribution is a unique aspect of qualitative research that adds perspective and depth to the results. However, this subjectivity could also undermine the credibility of the research if appropriate steps are not taken to reflect on these personal responses (Merriam, 2002). Reflection involves

acknowledging how the data may be influenced by the values, assumptions and background of the researcher.

Disclosing these assumptions, beliefs and biases that may shape the research is known as researcher reflectivity and allows readers to understand the position of the researcher and the context of interpretation (Creswell & Miller, 2000). Managing these personal responses may involve triangulation, whereby researchers engage with other researchers to crosscheck data and reduce any potential biases (Lincoln & Guba, 1986; Noble & Smith, 2015). These personal responses can also be managed through a process known as bracketing, in which a researcher deliberately defines their own preconceived beliefs and then actively puts these aside in order to alleviate some of the potential adverse effects of unacknowledged biases or preconceptions (Tufford & Newman, 2012).

Clarity in thought and transparency are also key aspects to the trustworthiness of qualitative research (Noble & Smith, 2015). This refers to leaving a decision trail through which readers are able to follow and verify the research process and decision making (Rolfe, 2006). Furthermore, it is important to ensure that interpretations of data remain consistent, and that there is a clear rationale provided for the basis of these interpretations (Noble & Smith, 2015). This rationale includes presenting verbatim participants' responses that are thick, vivid and rich in detail. This rich detail provides credibility to the theme presented, and allows readers to assess the applicability to other contexts (Creswell & Miller, 2000). The processes that ensure the trustworthiness and authenticity of qualitative research are described in relation to the current study in subsequent sections, including personal reflection and data analysis.

Personal Reflection

I have worked with children and families before conducting this study, primarily as a nanny and behavioural therapist. I had not worked clinically with children and families before conducting this research; however, this was my interest and the area I wished to pursue as a clinical psychologist. During the last year of my clinical training, I had the privilege of working therapeutically with children and their families. Throughout that time, I paid attention to my own CT reactions that I experienced, and often reflected on these with my supervisor. I was

not a part of any organisations in which participants worked nor did I know any of them personally.

I acknowledge that as a person I bring a history and possible biases into the study. I am the middle child of an intact family of five, and immigrated to New Zealand when I was an adolescent from England. I believe that this family background does shape my perspective and worldview. I consider myself caring and protective of others, particularly those who are vulnerable, especially children. It is also important to acknowledge that I do not have children, which may influence my perspective of parents compared to researchers or therapists who do have children.

In order to ensure that my own responses and potential biases minimally influenced the data and analysis, I employed a number of strategies. Primarily, this was through the ongoing review of the data collection, analysis and write up with my primary supervisor. During these meetings, the research process was reviewed. This included discussions about the initial coding, the development of themes, the naming of themes and the writing up of results. I also used a method of bracketing, in the form of writing memos throughout the data collection and analysis periods. Primarily, these were observational comments, my ideas, hunches and presuppositions. This enabled me to engage more extensively with the data.

Method

This section of the chapter outlines the methods used in this thesis study. The University of Auckland Human Participants Ethics Committee provided ethical approval for this research on 4th November 2019 (reference number 023531).

Recruitment

Following ethical approval, an advertisement (see Appendix A) was sent to the New Zealand College of Clinical Psychologists (NZCCP) who advertised the study to its members via their email list. The advertisement provided information about the goal, format and inclusion criteria for the study, and asked participants to contact the researcher if they were interested in taking part in the study. The study sought therapists working in all modalities, who had

worked with children and families within the last 18 months, and for a period of at least two years. Once participants contacted the researcher, they were emailed a participant information sheet (see Appendix B). Those participants who wished to take part in the research were then emailed a consent form to sign and return to the researcher (see Appendix C).

Participants

Fourteen therapists took part in individual interviews via Skype or Zoom, and the participant demographics are presented in Table 1. Twelve of the therapists were female and two were male. Therapists included 11 clinical psychologists, two psychotherapists and one psychiatrist. Eleven therapists completed most of their training in New Zealand, two in South Africa and one in Australia. Therapists' experience ranged between two and 30 years, with the mean length of practice being 14.6 years. Therapists worked from a range of models including psychodynamic, cognitive behavioural therapy, play therapy, family therapy and acceptance and commitment therapy. Nine of the therapists worked in publically funded child and adolescent mental health services, three therapists worked privately and two of the therapists were staff members in clinical training programmes.

Table 1

Participant Demographic Information

Characteristic	N
Gender	
Female	12
Male	2
Professional training	
Clinical Psychologist	11
Psychotherapist	2
Psychiatrist	1
Training in CT (post qualification)	0
Location of training	
New Zealand	11
South Africa	2
Australia	1
Therapies Practised	
Cognitive-Behavioural Therapy	9
Acceptance and Commitment Therapy	6
Play therapy	5
Watch, Wait and Wonder	3
Other Psychodynamic	2
Family Systems	2
Years practice	
2-10 years	4
11-20 years	10

Note. Total sample consisted of 14 participants.

Data Collection

All participants who met the inclusion criteria and wanted to take part in the study were scheduled for an interview. Interviews took place via Skype or Zoom due to participants being located in other parts of the country, and the move to online work due to Covid-19. Before completing the interview, participants were emailed a consent form to sign (see Appendix C). Participants were informed that they could stop the interview at any time without a reason.

All participants took part in a semi-structured interview (see Appendix D), which lasted between 43 and 93 minutes, with a mean time of 67 minutes. After collecting demographic information, the interview then proceeded to a discussion relating to participants' understanding of countertransference. Participants were then asked to describe countertransference experiences they have had while working with children and families. They were informed that all client information would remain confidential and that the research related to exploring therapists' experiences rather than those of their clients. During the interviews, I asked each therapist about the impact of his or her countertransference reactions on the therapeutic work, including the therapeutic relationship or outcome of therapy. Therapists were also asked how they managed their countertransference reactions, both within therapy sessions and outside of these, and to describe differences in therapeutic outcomes of managed versus unmanaged countertransference. Finally, therapists were asked what they thought would be useful for training and supervision of new clinicians.

Throughout the interviews, I attempted to create a non-judgemental, open and explorative environment, and encouraged participants to speak generally and also to provide specific examples. Therapists were prompted at times in order to gain an in-depth understanding of their experiences, such as "Can you think of another example where that reaction came up?", "What was triggering about that?", "Have you experienced anything similar or different to that?". Therapists were also invited to speak about anything they felt was relevant that had affected their experience or journey of understanding and managing CT.

Data Analysis

A University of Auckland approved transcriber who signed a confidentiality agreement (see Appendix E) transcribed all transcripts verbatim. Thematic analysis was used in this study to analyse the qualitative data. Thematic analysis is a systematic method of analysing qualitative data that identifies and organises themes across a data set (Braun & Clarke, 2012). The term 'theme' is used to describe a pattern of meaning that is common or shared in the data set, and the purpose of thematic analysis is to identify those that relate to the specific research questions (Braun & Clarke, 2012). Thematic analysis can be used across theoretical perspectives and frameworks, and provides a rich, detailed, and complex account of the data (Braun & Clarke, 2006).

Accordingly, thematic analysis was used in this study to analyse the data from therapists' individual interviews that explored their experiences of countertransference with children and families. An inductive approach was used for the analysis, in which coding was predominantly done from the data itself based on participants' experiences, (Braun & Clarke, 2012).

Braun and Clarke (2006) outlined six main stages in conducting thematic analysis. These six stages are recursive, in that movement occurs back and forth between the stages throughout the analysis as needed. These stages include (a) familiarisation with the data, (b) producing initial codes from the data, (c) sorting the codes into broader themes, (d) reviewing and refining the themes, (e) defining and naming the themes, and (f) final analysis and report writing. These are described in more depth below.

Step 1: Becoming Familiar with the Data

The first step was to become highly familiar with the data through repeated active readings. This is where, while reading the transcripts, I was actively searching for meaning, taking notes and developing ideas. This is referred to as "immersion" by Braun and Clarke (2006, p. 16). Although a University of Auckland approved transcriber transcribed all interviews verbatim, I checked them for accuracy. This ensured that extra time was spent reading each interview in order to become familiar and immersed in the data. While reading

the interviews, ideas and thoughts were noted, beginning the process of building possible themes and patterns.

Prior to moving to step 2, the data from the interviews was divided into five data sets related to the research questions and aims of the study. These included:

- Therapist conceptualisations of countertransference
- Triggers of countertransference in child and family therapy and the nature of these reactions
- Management strategies for countertransference
- Therapist perceptions of the impacts of countertransference
- Therapists' implications for training and supervision

Following this, a thematic analysis was conducted on each data set. Hence, the steps outlined below were carried out for each of the five areas above.

Step 2: Generating Initial Codes

The data were then systematically examined and initial codes were created and named, creating a comprehensive list of initial codes for each dataset. The software programme NVivo was used to organise and manage the initial codes, themes and to later refine these. As advised by Braun and Clarke (2006), I ensured that the data surrounding each code remained to ensure that no context was lost, and that code repeats were placed in as many different areas as was relevant to the context. Following this process, these initial codes were discussed with my primary supervisor.

Step 3: Searching for Themes

This phase of the analysis involved organising the initial codes into meaningful groups, which formed the basis of the themes. This process was repeated for each data set. Once an initial list of codes had been developed for each data set, the related codes were brought together into potential themes. As advised by Braun and Clarke (2006), while some codes did not appear to fit into the themes identified, it was important not to discard anything during this step. For example, for *Triggers of countertransference in child and family therapy and the*

nature of these reactions dataset, initial codes were brought together into nine possible related themes. These were:

- Working with child trauma
- Working with distressed families
- Working with entitled families
- Working with families who do not follow recommendations
- Working with families with high expressed emotion
- Working with families with parental mental health difficulties
- Working with friendly or idealising families
- Working with families that do not hold responsibility
- Working with socially isolated families

Step 4: Reviewing Themes

This stage involved refining the themes in each data set that were created in the previous step. The first level of refinement involved reviewing the coded data within each theme and assessing whether the data fit together meaningfully. If they did not, they were either removed from the theme, or the theme was given further thought. This process was repeated for each data set.

At the second level of refinement, I re-read the data set and examined the fit between the themes, to assess whether the themes accurately reflected the entire data set, and coded any further data that had not been previously coded. I also assessed whether the themes were clear and distinct from one another, and discarded any themes that lacked enough data to support them. This process was also repeated for each data set. For example, for the *Triggers of countertransference in child and family therapy and the nature of these reactions* data set, the themes were combined into five broader, more distinctive themes, which were:

- Working with children with safety concerns
- Working with families who oppose or disregard therapeutic recommendations
- Working with parental criticism and anger
- Working with families with a lack of resources
- Working with friendly or idealising families

Step 5: Defining and Naming Themes

This phase involved defining each theme by identifying the core essence of each theme and the aspect of the dataset it represented. This was done by conducting a detailed analysis on each theme, which involved identifying (a) what story the theme was telling, (b) how this fit into the overarching story, (c) how this fit in relation to the research questions and (d) how these stories fit in relation to each other. This phase also involved creating subthemes, which provided structure to themes that were larger or more complicated.

This process was completed for each data set. For example, for the *Triggers of countertransference in child and family therapy and the nature of these reactions* data set, the themes were renamed and the following subthemes were produced for each theme:

- When children are or have been at serious risk: child abuse and neglect, client risk
- When families want help but disregard therapists' input: narcissism or entitlement, lack of parental insight or responsibility, enabling or self-defeating patterns of behaviour
- When parents are critical and angry: anger and criticism directed towards children, anger and criticism directed towards therapists
- When families lack resources: internal resources (parents and their mental health difficulties), external resources (lack of social support)
- Being friendly or idealising the therapist

Step 6: Producing the Report

Writing the thematic analysis report involved describing and presenting the data in a way that told a meaningful story, illustrated the credibility of the analysis, accurately represented the data, and made an argument in relation to the research questions. Following the guidance of Braun and Clarke (2006), I chose extracts that provided evidence for the themes and of the narrative, and ensured these regularly occurred throughout. I then wrote the analysis, which was reviewed by my primary supervisor to ensure the narrative was cohesive and told a vivid and connected story.

Chapter Summary

This study followed a qualitative approach that investigated the CT experiences of therapists when working with children and families. It also explored therapists' conceptualisations of CT, the therapeutic impacts of CT and the strategies therapists used to understand and manage their reactions. Fourteen therapists self-selected themselves via advertisements to participate in individual semi-structured interviews via Skype or Zoom. An interpretive framework was utilised to position the research and understand the data. Thematic analysis, adopted from Braun and Clarke (2006), was undertaken to analyse the data.

Chapter Three – Results

This chapter presents the results of the thematic analysis of the first two datasets. First, the analysis of the ways therapists conceptualised or understood CT is presented. This is followed by the results of the thematic analysis of data relevant to the family behaviours and therapy situations that triggered therapist CT, along with the nature of these reactions. Quotes from the therapists illustrating examples of the themes of each dataset are provided as evidence and to capture the therapists' views.

Thematic Analysis: Therapists' Conceptualisations of Countertransference

This chapter presents the results of the thematic analysis of data pertaining to the ways therapists conceptualised CT. During the interviews, therapists were asked to describe their understanding of CT. Several ways of understanding CT were spoken about, which provided insight into the ways therapists made sense of their reactions towards children and families. Four main themes were identified, which reflect the ways therapists conceptualised CT. These were *Countertransference as Primarily an Emotional Response, Countertransference as Normal or Inevitable, Countertransference as a Source of Information, and Countertransference as a Relational Process.* Table 2 shows the number of therapists who endorsed each theme.

Table 2

Therapists' Conceptualisations of Countertransference - Themes

Themes	N=14
Countertransference as Primarily an Emotional Response	10
Countertransference as Normal or Inevitable	8
Countertransference as a Source of Information	6
Countertransference as a Relational Process	12

Theme One: Countertransference as Primarily an Emotional Response

Many therapists reflected that CT is primarily an emotional reaction that occurs in the room in response to clients. They used the terms "emotional experience," "emotional response," and "emotional reaction" to describe their understanding of CT and how they experienced it. They described CT as feelings, for example "the feelings that we experience as therapists in regards to our clients" (Participant 4), and "it's really more described as, 'I felt'" (Participant 14). Although CT was predominantly described as an emotional process, some therapists also perceived CT to includes a "rational process" (Participant 2) or a "cognitive" component (Participant 6). Participant 2 elaborated on this, as the "thoughts, emotions, images, symbols, experiences, memories and states" (Participant 2) that occurred in response to a client. Some therapists believed that CT reflects a more intense emotional response, for example, the "emotional heat of the CT stuff is stronger" (Participant 3); and CT is "a reaction or feeling that you are left with that might feel a bit foreign or larger or stronger than other feelings" (Participant 5).

Theme Two: Countertransference as Normal or Inevitable

The second theme to emerge was the normality and inevitability of CT. Participant 2 believed that therapists "can never be just a plain blank canvas" that only reflects one client's experience at any given time. Therapists bring things into the room with them, including their history, experiences and emotions. They spoke of the inevitability and unavoidable nature of

CT when working with other people, for example, "as soon as there is another person in the room with you, there is something" (Participant 9). They agreed that CT inevitably occurs and "if you think it's not there it's probably because you're not aware" (Participant 2). They expected CT to occur for all therapists, and felt they were open to this experience. For example, "it's expected that this is going to happen and there's nothing wrong with it" (Participant 4) and "this is likely to happen to you" (Participant 6). Many participants reflected this inevitability as an example of therapists being human. For instance, Participant 1 explained, "we're humans and therapy is subjective … so our reactions are going to influence where we go and what we choose to attend to."

Theme Three: Countertransference as a Source of Information

Many therapists regarded CT as a source of information about the client or family. These therapists considered CT to be an important area of insight into their clients' "internal world" (Participant 7). For instance, Participant 5 reflected, "I might be the vessel for some very strong feelings that the young person has." Additionally, some therapists considered CT provided them with information about their own inner experiences and the therapeutic relationship. Participant 7 saw CT as information. She explained, "It's information about myself, about the client, about the dynamic between us, the relationship" (Participant 7). Participant 10 perceived CT as a "window onto that emotional world – your own and others." Due to the valuable information that CT has provided many of the therapists in the past, they considered it an important "assessment skill or tool" (Participant 4).

Furthermore, some therapists believed that CT provided information on the clients' early experiences or relationships with others. Participant 5 learned helpful information about a client's early relational experiences through CT. She noticed she was being "drawn into patterns" that she believed were "replicating relationship patterns experienced before." CT reactions were also useful in helping participants understand how other individuals in the clients' lives perceived and responded to them. As participant 6 said, "if actually somebody was kind of irking everyone, it's probably a good sign that they're gonna get people responding to them in that way." Finally, some therapists used their CT reaction to understand how family members may have felt in response to other family members or relationship dynamics within the therapy room. For instance, when working with the family

of a young boy, Participant 2 experienced a CT reaction which was "very much a feeling of a significant amount of sadness that's his; it is his through and through" (Participant 2).

Theme Four: Countertransference as a Relational Process

Finally, the majority of therapists viewed CT as a relational process which sits in the "resonance space" (Participant 12) or "liminal space" (Participant 8) between clients and therapists. Therapists thought that CT comes from "joining the relationship" (Participant 4) and "the work that needs to be done to build and maintain relationships" (Participant 2).

The majority of therapists perceived that their CT arose from a combination of features from both therapists and clients. They believed it was important to understand what they, as therapists, were bringing into the room and into the relationship, including their own personal histories, experiences and emotional triggers. They felt that the "things that might trigger emotional responses are individual" and "separate to the client relationship" (Participant 12). This was important as these past experiences and relationships could be projected onto the client or interfere with the therapeutic relationship or process if not understood. As a result, therapists asked themselves questions such as "Is this a reaction about my past? Is it from events in my life that I'm putting on them that actually they haven't elicited?" (Participant 11). Other therapists sought to identify what they brought on a particular day, such as a lack of sleep, as this could also influence the CT reactions. As Participant 9 said, "sometimes those reasons are nothing to do with the client and everything to do with you having a difficult day."

As part of this relational process, therapists thought that it was equally important to understand what their clients brought into the room and into the therapist-client relationship. This included the clients' transference, or projections onto therapists, and the clients' behaviours, characteristics or ways of interacting with, or relating to, therapists. Therapists thought that these reactions were often "based on the clients' history, based on the circumstances which are happening" (Participant 7) and based on their other relationship patterns and behaviours. Many therapists spoke of how CT arose from interactions between clients and therapists. For instance, Participant 13 described these as "the processes that are evoked in the clinician as a result of that encounter which in part is to do with how the patient is interacting with you, but also partly on your own previous experiences" (Participant 13).

Therapists believed it was important to understand where the CT reaction came from and to separate their own reactions from their clients. This separation was important because it influenced what therapists did with CT experiences. However, this differentiation could sometimes be "really obvious … and other times it's really subtle" (Participant 7).

Summary

In summary, therapists in this study conceptualised or understood CT in four main ways which captured different aspects of CT. Therapists spoke about CT as primarily an emotional response, which could also include cognitive components. Second, many therapists understood CT as normal and inevitable, occurring to all therapists regardless of training or experience. Third, some therapists conceptualised CT as a source of information about the client, themselves or the relationship, which could be used to inform therapy and guide treatment. Finally, most therapists spoke about CT as a relational process, arising from both client and therapist contributions.

Thematic Analysis: Triggers of Countertransference in Child and Family Therapy and the Nature of these Reactions

This section presents the results of the thematic analysis of the data related to therapists' experiences of CT when working with children and families, following a brief exploration of the perceived differences in CT reactions when working with children and families compared to working with individual adults. Therapists were asked to recall times they experienced a CT reaction when working therapeutically with children and/or families. Five main themes were identified which capture the therapy situations and/or child and family behaviours that triggered CT reactions for therapists. These were: *When Parents are Critical and Angry, When Families want Help but Disregard Therapists' Input, When Children are or have been at Serious Risk, When Families Lack Resources*, and *Being Friendly or Idealising the Therapist.* In the following section, these five themes and related subthemes are presented, alongside the types of CT reactions that were triggered for the therapists. The five themes and subthemes are presented in Table 3, including the number of therapists who endorsed each theme. Following this, some of the influences on therapists' experiences of CT are examined, such as years of experience and whether or not they have children.

Table 3

Triggers of Countertransference Reactions – Themes and Subthemes

Themes and Subthemes	N=14
When Parents are Critical and Angry	14
Anger and Criticism Directed Towards Children	11
Anger and Criticism Directed Towards Therapists	10
When Families want Help but Disregard Therapists' Input	13
Lack of Parental Insight or Responsibility	9
Enabling or Self-Defeating Patterns of Behaviour	7
Narcissism or Entitlement	4
When Children are or have been at Serious Risk	12
Child Abuse and Neglect	10
Client Risk	6
When Families Lack Resources	11
Parents and their Mental Health Difficulties	10
Lack of Social Support	4
Being Friendly or Idealising the Therapist	3

Therapists spoke of how working with children and families affected their CT reactions differently to working with adults individually. These differences are important in providing relevant context and background to their reactions since they may differ from results of other adult CT literature. Therapists discussed the difference in content, intensity and complexity of CT reactions. Many therapists perceived that CT was stronger in children and family therapy due to children's level of vulnerability, powerlessness and dependency, as well as the added

responsibility therapists felt "to provide that safety and security and that kind of safe environment for them to express themselves emotionally" (Participant 12). Participant 7 talked about the powerful impact that children can have on therapists:

> Because children perhaps, certainly the littlies, are not able to articulate their internal world necessarily through language, so clearly it will come through in their behaviour. And so sometimes that can be, I don't know, I wonder whether that's really powerful because sometimes that's more unconscious, I don't know. And because children are dependent and reliant on their key attachment relationships for survival and for their wellbeing, I wonder for me whether my response, sometimes I find it perhaps easier to identify with their vulnerability and their neediness more than perhaps I would an adult.

Therapists considered CT to be more intense in therapy with parents as therapists felt more aware of the impact of their client on somebody else, and the pressure that came from knowing "if anything's going to be different for that child you need to help the parent see the child differently and so it's really critical" (Participant 10).

Finally, therapists described the different CT experiences of working with children and families compared to working with individual adults. Therapists thought that working with children and their parents more easily elicited their own childhood experiences, and their own experiences both of being parented and of parenting compared to adult work. However, in adult work, therapists felt that CT is based more on what clients bring into the room. Therapists also spoke of more positive feelings when working with children, as physical contact, such as hugging, is more common with children. Moreover, some therapists believed that their CT reactions were more complicated when working with families due to there being more sources of CT reactions, including to each individual, each relationship dyad, sub-system and the family system as a whole. The triggering family behaviours and therapy situations are now explored with their associated CT reactions.

Theme One: When Parents are Critical and Angry

This theme refers to therapists' experiences working with parents they perceived to be critical, hostile, angry, blaming and invalidating. As Table 3 shows, angry and highly critical parents triggered a CT response for all of the therapists in this study. This theme is divided into two subthemes based on whether the criticism and negative emotion was directed at the children or at the therapist, as this resulted in different emotional CT responses for therapists.

Anger and Criticism Directed Towards Children

When reflecting on their CT experiences, the majority of therapists considered parents or caregivers hostile if they were critical, shaming or invalidating towards their children. Therapists observed parents "attacking their child" (Participant 10), "being very much a critical parent and a little bit harsh" (Participant 12), and "critical and very shaming or non-accepting" (Participant 9). Some therapists also spoke of parents who openly blamed the child for being or causing the familial problem for which they were seeking help. As one therapist said, "the mother needed me to trust her that this was a bad child and that there was something wrong with it" (Participant 10). Another therapist reflected on a similar parental attitude of blame with "there's just something really screwed with this kid" (Participant 3).

Many therapists reported that they found it difficult to work with these families as they often brought up feelings of frustration, anxiety and anger. These therapists thought the frustration was the result of noticing the impact the parents were having on the child. Therapists spoke of children who would "shut-down," such as Participant 5 who explained, "You start to notice this is all about the parents and the animosity and the kids don't feel safe talking, or sharing, or telling you anything." Alternatively, therapists felt frustrated when they noticed that some children felt "worthless" as a result of their parents' critical comments. This frustration also occurred when parents did not notice the impact their criticism and invalidation had on their child:

> When you see that happening and here's a child that's really struggling and this parent is not aware of how their harshness or that more punitive demanding sort of parenting space is impacting on this child. (Participant 12)

Several therapists felt angry towards critical and invalidating parents. This was because these parents were "unwilling to step up" (Participant 11) and be there for their children or they responded to their children in ways therapists did not think was appropriate. Therapists' anger was amplified by the vulnerability of children because they "can't do this on their own" (Participant 10). One therapist reflected on her anger towards hostile parents on behalf of the child:

> Holding a bit of, or a lot of, anger of, you know this was your choice. It was not my choice to have you, it was your choice to have me. There's this quote that says every child deserves a parent, but not every parent deserves a child. (Participant 2)

Finally, some therapists talked about anxious CT reactions they experienced in response to parents they perceived to be highly critical and aggressive towards their children. These therapists worried about the unpredictability of these parents with aggression and conflict that was quick to escalate. This could be "conflict between the parents or conflict between the parent and child" (Participant 13) that evokes anxiety in some therapists. Participant 10 recalled working with a "very attacking mother" and "getting anticipatory anxiety left alone in the room because I would just have to wait for the attack." Sometimes therapists also talked about feeling protective of the child, and both sadness and empathy for the parents. This empathy occurred if therapists knew "that there was reasons behind that for her" (Participant 9), and "that tells me that their experience of being parented was probably very similar" (Participant 10). Finally, some therapists were reminded of their own upbringings, such as Participant 5:

> And you're just, and I feel like a little kid. And it's a little bit, and some of that is about wanting so desperately to be loved and liked by your parents. And that sense of disappointment, knowing what that feels like and being able to react to that in my own life, in my own experience.

Anger and Criticism Directed Towards Therapists

Many therapists spoke of the effects of parental anger, hostility and invalidation directed towards them. Therapists talked about anger and conflict from parents who "yelled" at them (Participant 1), sometimes to a "full blown … real attack" (Participant 10). Sometimes this anger resulted in swearing at therapists. They spoke of the unpredictability of clients' anger, causing "discomfort, wariness of, 'I'm maybe about to take a fall here'" (Participant 6), and needing to "brace myself … And so you never knew when she would kind of, when she was gonna flip" (Participant 9). Some therapists perceived that parental anger directed at them sometimes came from a place of parental care and protection, such as when parents did not perceive the therapist to be anxious enough about the young person or not making diagnoses that the parents thought were appropriate in order to get access to services.

Many therapists reported that they found it difficult to work with critical parents who directed anger at them. Predominantly, these parents brought up CT reactions of anxiety and fear in therapists, as a result of aggression towards them or "aggressive demeanours," particularly from men (Participant 11). Criticism from parents also led to feelings of incompetence and discomfort in some therapists, due to feeling "judged, or challenged, or belittled" (Participant 7). Some therapists also felt incompetent when they perceived their efforts to support the family were invalidated by parents, particularly when therapists felt they had done a lot to support them. Other therapists felt scared and intimidated in response to these parents, and felt a need to protect themselves. Participant 7 explained her reaction to a critical parent:

> There'll be times in the room where we, my colleague and I, feel quite dismissed, where she's quite disparaging in her comments. And so for me, my countertransference is feeling that, yeah, feeling disempowered, feeling uncertain of myself. At times I feel angry or frustrated with her.

Theme Two: When Families want Help but Disregard Therapists' Input

This theme refers to therapists' CT experiences when they perceived families opposed or ignored their therapeutic recommendations at the same time asking for their help. This included both active opposition and passive disregard of therapists' input, and resulted in the failure to follow recommendations, take on board suggestions, or make meaningful change.

This theme is divided into three subthemes relating to the reasons behind the lack of change. These are *Lack of Parental Insight or Responsibility, Enabling or Self-Defeating Patterns of Behaviour,* and *Narcissism or Entitlement*. Each subtheme is associated with different CT reactions.

Lack of Parental Insight or Responsibility

This sub-theme refers to therapists' reports of CT reactions to parents they perceived to have "minimal insight" into the child or family's problems. Minimal insight refers to parents who were unaware of the impact that they had on their children and how they contributed to the problem. Some parents did not seem able "to notice that, or see that, or accept that, or accept their part in being able to provide something different" (Participant 7) for the child.

Therapists also felt that some parents were unaware of the impact their parenting behaviours had on the children. These parents appeared to believe that the child was the problem, and wanted the therapists to "fix their child" (Participant 10). The therapists found it difficult to encourage these parents to acknowledge their role in maintaining the problem through their own behaviour and through the parent-child relationship. Therapists felt frustrated because this lack of insight prevented change. As one therapist reflected:

> I suppose it's really the ones that don't make any changes. You know like they keep coming to therapy and they keep on with that same story that the child is the problem. And then we'll just talk about it but actually they do nothing different. (Participant 11)

Most therapists reported frustration as their primary CT reaction. This is because they found it difficult to help parents notice their own role in the problem and respond differently to the child, thereby creating positive change within the family system. Some therapists also reported frustration and anger over the lack of responsibility that some parents took, as discussed by Participant 14:

> I was left with the young person struggling in this dynamic that wasn't working, with the adult really taking very little responsibility. So I sometimes felt a degree of anger, a degree of frustration in trying to fix it.

Another therapist talked about feeling powerless and being set up to fail with this type of parent. She used the metaphor of a dustbin to describe this:

> Whoever presents to service, say if a six-year-old client is kind of like the emotional dustbin of the family. And the dustbin is now full and it no longer takes any trash and nonsense, so it's actually the dustbin is not working anymore. So that's when the family rocks up to service and says little Jonny needs intervention because he doesn't work as well as he should. Because essentially the dustbin is overflowing. And so with that lens I feel like at times that can set me up for failure in empowering, or it can sometimes set me up for challenges to get the parents' buy-in for us to be a team. (Participant 2)

These feelings of powerless usually occurred when therapists felt caught in a difficult position between parents and children, in which they were trying to both "amplify the child's voice" to try and increase parents' awareness of their behaviour, but also "maintain the parents' buy-in" (Participant 2) in the therapeutic relationship and process.

Enabling or Self-defeating Patterns of Behaviour

This sub-theme relates to therapists' perceptions of their CT reactions to families reluctant to change the current family system or the interactional patterns of the family. Some therapists reported a "high degree of avoidance" (Participant 1) of change with some families, because the process of change could bring too much emotional distress for its members. For instance, one therapist talked about parents perceived to "enable the child's avoidance" of the anxiety-provoking stimuli for which the family was seeking help, contrary to therapist recommendations. This was because they "found it so incredibly challenging to tolerate the young person's distress" (Participant 1) when the child was exposed to the stimuli. Alternatively, sometimes family members benefitted from the problem behaviour for which they were seeking help. For instance, Participant 4 recalled working with a parent of a highly anxious child. This therapist thought the parent had "a level of investment in keeping the child this way because the child provides a level of safety" for the parent, in that caring for the child provided comfort and distraction from other difficulties. Therapists felt frustrated with these parents who inadvertently enabled or behaviourally reinforced the behaviour for which they were seeking to change within therapy.

A couple of therapists also spoke of clients, particularly adolescents, who were reluctant to change themselves. These clients were labelled "yes but" individuals in which "everything you suggest they've tried or it doesn't work" (Participant 12). The therapists believed that this reluctance to change could have been due to a level of dependency on the therapist, or a reduced "sense of any agency" (Participant 12) in the young person. Alternatively, some adolescents could be unmotivated to change due to parents who unintentionally enabled or reinforced behaviour that they had initially sought help to change. For instance, one therapist became frustrated when working with an adolescent boy, referred by his parents to change his lifestyle to improve his wellbeing. This therapist recalled considerable difficulties "trying to elicit some motivation from him" for change and sensed that he was not engaged in the therapeutic process (Participant 1). However, the therapist noticed that the boy's parents were positively reinforcing his lifestyle at home by "paying for everything he needs", and negatively reinforcing his behaviour by not requesting that he do "anything he doesn't want to do". As such, the boy had little reason or motivation to change.

Therapists often described feelings of frustration when working with enabling and self-defeating patterns of behaviour especially when there appeared to be a clear solution based on the therapists' recommendations. For some therapists these feelings of being stuck led to feelings of hopelessness about the possibility of achieving change, or concerns that they would contribute to the unhelpful pattern. As one therapist reflected:

> I think I find it frustrating because in those situations where there is a high level of anxiety, although it's extremely hard for the family, it can actually be quite clear what they need to do in order to resolve the issue. And so then when people aren't able to take on board any recommendations or do things or it's just too hard for them to do things differently. I feel empathy for them, and I can kind of see that but it's that anxiety I feel, I mean I find that frustrating in terms of there is a risk that I start to feel like I'm stuck with them. (Participant 1)

Another cause of frustration was avoidant families who repeatedly missed appointments or refused to engage with the therapist in the room or answer questions.

Narcissism or Entitlement

Working with parents whom therapists described as "narcissistic" or "entitled" also created CT experiences for therapists in their work with families. These parents came across as "thinking that they know better" (Participant 8) than the therapists, and not listening to the therapist. Therapists observed that these parents did not take their suggestions on board, follow their guidance or accept their support. Therapists found the clients they perceived as "narcissistic" difficult to work with and recalled CT experiences of feeling incompetent and feeling a "need to prove to them that I'm good enough" (Participant 11). Therapists also reported feeling defensive, and "backed up against the wall' (Participant 8) in response to these parents.

Other therapists described some parents and families as "entitled" with an "attitude of kind of like, you'll just fix it for me" (Participant 9). These parents did not want to be involved in the therapeutic process for their child. Rather, they expected "that we would kind of look after her and get her better" (Participant 13). Therapists reported feelings of anger when working with entitlement, due to the lack of perceived care and support from the parents in the child's wellbeing, as outlined by participant 13:

> My countertransference is to entitled families, seeing families who come, you know, from pretty affluent backgrounds where the children are struggling and yet the parents, yeah don't, have a hard time prioritising the care of their children over their careers or work commitments.

Theme Three: When Children are or have been at Serious Risk

This theme relates to therapists' experiences of CT when working with families in which there were current safety issues and/or historical safety concerns. This theme includes two subthemes, *Child Abuse and Neglect* and *Client Risk*.

Child Abuse and Neglect

Several therapists talked about their CT reactions and responses to working with abuse and neglect towards children within families. Child abuse and neglect included instances of child sexual abuse, physical abuse, emotional abuse, witnessing interpersonal violence, and neglect. Therapists talked about families in which abuse was occurring or had occurred within the home or family environment. They spoke of the challenges of care and protection issues and the need to notify the child protection service, Oranga Tamaraki (Ministry for Children) when there was risk present to the child at home. Although therapists knew that making this report of concern was their responsibility, they found it "really distressing to have to do because you know the outcome, or the consequences and how this is going to be harder for the family" (Participant 14). Therapists also found it difficult to inform these parents about their notification.

Therapists' emotional responses to children who had been exposed to abuse and trauma were sadness, anger, frustration, despair and distress. Therapist anger and frustration was typically directed at wider structures that placed children in vulnerable positions, or in regards to "hearing about what's happened" to the client (Participant 14). Distress and sadness often occurred for therapists in response to the presentations of traumatised or abused children, such as when the child "totally shut down and cried" (Participant 1) or appeared "lonely, sad, and upset. And tired, and lost, and confused". Some therapists thought that their sadness was a shared experience with children in which the therapist held or mirrored the child's emotions in the room. Feelings of despair arose when therapists felt as though they were not "necessarily actually going to be able to help" (Participant 14) the child

or adolescent. Finally, one therapist felt a strong "ache" in response to child neglect. This therapist was concerned that neglect was not detected as readily as other forms of abuse, and could lead to children's suffering going unnoticed. Moreover, the absence of "consistent emotional care and nurturing" and the sense of "the child struggling, having to kind of fend for themselves more than perhaps they ought to" led to this strong feeling of ache (Participant 13). Participant 1 reflected on the range of emotions she experienced when working with abused and neglected children:

> In circumstances where there is child abuse and neglect and working with children who have been exposed to horrendous trauma, that brings up feelings of sadness and distress. And at times anger and frustration, not necessarily towards clients but towards the systems that don't work well for these children.

Many therapists also experienced an "urge to boundary cross" and a "desire to rescue" children who had experienced abuse and trauma. Urges to boundary cross included "urges to help" and "urges to fix it" for the child, beyond what the therapist would usually do for a client. For instance, Participant 1 felt a powerful urge to boundary cross when working with a twelve-year-old female who had been sexually abused by her ex-stepfather. This urge resulted in this therapist "working really hard" to try and "fix it for her". This was amplified by the therapist moving to a different part of the country with her family, and the pressure she felt to fix things for the young person beforehand. Participant 11 also felt the urge to boundary cross and take home a seven-year-old male that had ongoing care and protection issues at home. This therapist had to remind herself that her role was not to take him home or rescue him, but to inform the appropriate agencies (Oranga Tamariki) and to support him through his experiences. Therapists who experienced the desire to rescue children often noticed a yearning to take the child home with them in order to "make it all better for them" and "show them a different experience of life" (Participant 4). As one participant said, "I think that by coming with me, they'll feel loved and everything will be perfect for them" (Participant 4). This therapist noticed the desire to rescue as "a pretty consistent theme" she experienced when working with children who have been through abuse. These therapists did not report acting on these urges, but said they needed further support from colleagues and supervisors in order to manage them.

Two therapists spoke of how this urge to go beyond their professional role could also occur when they were working with children and adolescent clients who had been sexually abused in the past. These clients sometimes "try to elicit you" (Participant 14) or "draw you in" (Participant 5) to "cross the boundary". For example, Participant 5 reflected on an experience working with a 10-year-old female who had been sexually abused by an extended family member in the past. This therapist noticed "a very strong feeling of connection and I wanted to do lots of things for her and I thought about her a lot". This was because she felt "loved and adored" by the young client.

Client Risk

Therapists talked about their CT reactions when working with clients, often adolescents, who were engaging in risky behaviours such as preparing for suicide, cutting, injecting, at risk of overdoses, and suicide attempts. Working with children at risk brought up strong CT reactions. Typically, "risky clients" resulted in therapists experiencing anxiety. For some, their own history and knowing people who died by suicide increased this anxiety and fear. For instance, Participant 1 said:

> I've known people to have died by suicide, so that maybe makes me more, a bit more anxious. Although I'm very, I try very hard not to be risk averse because I see lots of that in our systems. But maybe, maybe that makes me feel more anxious with more risky clients.

The second most common CT experience for therapists was a strong feeling of responsibility. Participant 1 "felt anxious" when a 17 year old boy planned to suicide. "I really felt like I needed to convince him not to kill himself and that was a very heavy weight that I placed on myself." Some therapists required further collegial support with their anxiety to "help me put the boundaries in my mind again about what my responsibilities are and what the task is at hand" (Participant 11). Other therapists' CT reactions to risk included feeling "overwhelmed" (Participant 11) and "strong empathising" with a distressed parent (Participant 3).

Theme Four: When Families Lack Resources

This theme refers to the CT reactions that therapists experienced when they felt unable to help children and families because the family lacked the internal and/or external resources for the therapeutic work to occur. This theme is divided into two subthemes: lack of internal resources, which refers to the parents' own mental health issues; and lack of external resources, which refers to the lack of social and practical support available to the family. These circumstances resulted in different emotional responses for therapists. Therapists thought these factors needed addressing before any work could be done between child and parent.

Parents and their Mental Health Difficulties

The majority of therapists had CT reactions as a result of parental mental health difficulties when working with children and families. They thought that parents' own mental health problems had a significant impact on their children and family functioning, and at times presented a significant barrier to therapeutic work. For instance, some parents with their own trauma history were observed to be "triggered" when their children had similar traumatic experiences to their own. Therapists thought that these parents were "unable to parent" (Participant 11) or to be there for their children in their distress. In other situations where parents had experienced a trauma not shared by their child, therapists observed that a parent may not be able to "get beyond her own emotions and just regulate to be able to actually look out and notice that there was child" (Participant 6). This kind of situation was reported by several therapists between babies and mothers who had significant trauma histories. It was considered a substantial barrier to therapeutic efforts to support the parent-child relationship.

Therapists talked about various ways in which parental mental health difficulties affected children's functioning and treatment. First, some therapists noticed that parents were avoidant about accessing their own support that could be beneficial for the parent, child and family, or avoidant of implementing treatment recommendations. Participant 4 thought that this may have occurred for one mother because she had a "level of investment in keeping the child this way because the child provides a level of safety for her in not having to do her

trauma work". Conversely, other therapists observed some parents used sessions that were supposed to be working on the parent-child relationship for their "own needs" and talked about themselves, unrelated to the child (Participant 7). This impacted the therapeutic work and also was observed to impact the child, with some appearing "lost" and ignored, while other children appeared to "take care of the parent" (Participant 4).

Some therapists discussed parental anxiety in particular and how this could "flow onto the child" (participant 12). One therapist reflected on a family that presented to service for support with the child, however they "quickly worked out … the kid, there's nothing wrong with him" (Participant 11); rather the mother needed her own support for anxiety and trauma. Participant 12 described similar circumstances with a family in which the child had "a little bit of anxiety but they're actually okay". However, this therapist noticed, "the parents' anxiety has become so concerning for the child, or their concern for the child has ended up with the child developing things so similarly".

Working with parental mental health difficulties brought up feelings of frustration and sadness for many therapists. Therapists felt frustrated and stuck, unable to make progress with these children and families, often because the parents were perceived to need their own individual support before the relationship work could occur. For instance, Participant 6 tried "multiple different ways to help her be able to make a bit of a shift on things. And it just didn't happen" because the mother's own mental health difficulties required individual support. Participant 2 reflected on why some parents require their own therapy before family interventions are effective:

> Parents whose inner children have unmet needs, really if they are unable to meet the unmet needs of their (own) inner children, and they have this child with unmet needs. Then sometimes it has to start with their inner children first.

Participant 6 experienced sadness and frustration after watching a mother's "own experience as a child and emotional neglect … replay again for her child." Another felt "anger and frustration" in response to a mother who was not able to meet the needs of her child. Finally, one therapist, in response to a mother who "functioned like a child" and was not getting her own parental support, experienced a feeling of "wanting to protect and be the parent" (Participant 11).

Lack of Social Support

Therapists spoke about the impact of a lack of social support for some families when reflecting on their CT reactions when working with children and families. These families had limited assistance available and felt a lack of connectedness to others and their community. Several therapists spoke of how hard they perceived it to be for some solo parents with the requirements of therapy and caring for children who were struggling, alongside other parental responsibilities. These therapists noticed that although a lack of external social resources often resulted in "shortcomings in the care" (Participant 13) of children, they felt empathic, understanding and compassionate towards these families. For instance, Participant 13 noticed that solo mothers often elicited feelings in him of wanting to "try and fix things, or wanting to try and help and make things better, you know, more so that I might have an intact family". This therapist observed his "affinity" with "solo mums who kind of work hard for their kids" because of his own experience of being solo parented. Another therapist reflected on a CT reaction to a mother who received limited support from others:

> And I felt exceptionally sorry for her and very empathic, just kind of, I felt I guess her 'stuckness' and difficulty leaving and working out what on earth she could do. And kind of questioning of herself and in doubt and uncertainty about what was the right thing to do. And knowing that there was no, like, there was no more support, I guess her lack of sense of support as well very strongly. (Participant 6)

Participant 1 talked about an adolescent who "didn't have a real sense of connectedness to anyone" and held the belief "that there is no meaning in life, and that he would never have meaning in his life because of his lack of social connection." This brought up sadness and compassion for this therapist in response to this client.

Theme Five: Being Friendly or Idealising the Therapist

Some therapists spoke about their CT reactions to friendly families or families who idealised them when reflecting on their CT reactions. This theme was the smallest of the themes to emerge from the data. However, these families remain distinctive from the other families discussed so far, and brought up very different CT reactions for therapists.

Therapists talked about friendly and positive children when reflecting on their emotional responses to some families. One therapist remembered a child who consistently

appeared pleased and excited to see the therapist, and the therapist's reaction that, "there is a child that is very idealising and loves to come to therapy and is so excited, and it makes me feel really good" (Participant 7). Other therapists talked about how children also initiated physical contact with the therapist, such as through hugs or sitting on their knee. These children tended to bring up positive feelings for the therapist, such as warmth. These positive feelings were sometimes enhanced as a result of the therapist being reminded of their own children. However, some therapists were concerned that a child's closeness with them could also "be a problem" as it may be a reflection of "what this client isn't getting from their key relationships" (Participant 7) or it might represent a vulnerability or risk factor for the child.

This theme includes family members (parents and children) idealising the therapist. Some therapists recalled that parents sometimes attributed positive change to the therapist, such as "You're the one that made everything change for me and this is all because of you" (Participant 6). This led to mixed feelings for the therapist, who felt "uncomfortable" as it appeared as if the client undermined their own "sense of potency in the changes they've made" (Participant 6). On the other hand it was nice to be perceived as having "done something useful for them" (Participant 6). This also led to some concern that this idealisation could fluctuate to "devaluation", with some apprehension about when this change would occur for the client. Finally, therapists reported feeling special, that they had "made a difference" for the client (Participant 7) or by recognising "that there's been something special that's happened in the therapeutic relationship" (Participant 6).

Influences on Therapists' Experiences of Countertransference

Many therapists thought that their experience of CT had changed over time, as a result of variables such as experience level and having children. This section briefly describes how these circumstances influenced therapists' experience of CT with children and families. The majority of therapists felt that their CT reactions had changed as their level of experience grew. As newer clinicians, some therapists were more avoidant of emotional experiences in sessions and fell "into the rescuing trap" more (Participant 4). They also believed they were quicker to attribute CT to the client rather than themselves and had more feelings of incompetence and anxiety as newer therapists. As their length of experience increased, some therapists felt less overwhelmed by CT reactions as the intensity of them diminished and "the

discomfort of them is familiar" (Participant 11). However, one therapist thought that CT reactions could become more complicated over time, as they also involved previous clients they have had CT responses to.

Some therapists who had children during their careers spoke about the impact that this had on their experience of CT. These therapists felt they responded to parents with more compassion and empathy since having their own children, as they had a greater understanding of "what the challenges of parenthood actually are" (Participant 4). Before they had children, some therapists thought that their CT was more "judgemental", with "higher expectations" of parents (Participant 10). Participant 4 also felt that having children reduced her CT reaction of wanting to bring children home with her, due to being more "depleted" and understanding the "resiliency of children within themselves." Some therapists with children also thought that their CT reactions were "a lot stronger" after having children because of the additional place the CT can come from. As well as the "CT from your own childhood" (Participant 3), there are "your own kind of experience of being parented, but it also brings up, for me, it brings up a lot about my own parenting" (Participant 8). Hence, years of experience and having children could influence therapists' experience of CT, however in different ways for therapists.

Summary

In summary, all therapists identified numerous CT reactions that they experienced in their therapeutic work with children and families. Five main types of child and/or family behaviours and therapy situations were identified that triggered CT reactions. Parental anger and criticism, directed towards children or the therapist was a common trigger for CT, often leading to anger and anxiety for therapists. Therapists spoke about the frustration that often occurred when working with families who disregarded therapeutic input and recommendations and did not make progress but continued to seek help. Client risk and safety concerns was a strong trigger for therapists, including responses of anxiety, fear, feeling responsible, and wanting to protect and rescue children. Families that had limited personal and interpersonal resources brought up feelings of frustration, sadness and empathy for many therapists. Finally, some therapists talked about positive CT in response to friendly or idealising families. Additionally, therapists spoke about the difference in CT reactions

between working with children and families compared to working with individual adults, describing CT to children and families as stronger and more complicated.

Chapter Four – Results

This chapter presents the results of the thematic analysis of three data sets related to the studies' research questions. These are: the strategies therapists engage in to manage their CT responses, therapists' perceptions of the impact of CT on the therapeutic process, and therapists' perceptions of the implications and recommendations for training and supervision. Quotes from the therapists illustrating examples of the themes for each dataset are provided to demonstrate the theme and the therapists' views.

Thematic Analysis: Managing and Utilising Countertransference Reactions

This section presents the results of the thematic analysis of data pertaining to the ways in which therapists managed and utilised their CT within and outside therapy sessions. Five main themes were identified which capture these CT management strategies. These were *Awareness and Reflection; Within-Session Management Strategies; Pre-Session Management Strategies; Utilising Countertransference;* and *The Importance of Supervision, Personal Therapy and Colleagues.* These themes and subthemes are presented in Table 4, along with the number of therapists who spoke about each theme. The section will then briefly explore some of the influences on therapists' abilities to manage their CT, including length of experience and caseload.

Table 4

Managing and Utilising Countertransference Reactions – Themes and Subthemes

Awareness and Reflection	14
Awareness of Emotional Experiences	9
Awareness of Personal History	7
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Awareness of the Role and its Limitations	4
Awareness of Self-State	4
Reflection	12
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Within-Session Management Strategies	14
Utilising Countertransference	13
The Importance of Supervision, Personal Therapy and Colleagues	12

Theme One: Awareness and Reflection

Existing research highlights that an awareness of CT reactions is the first step for therapists to be able to effectively manage them (Hayes et al., 2018; Hayes & Gelso, 2001; Mojta et al., 2014). Most therapists echoed this and spoke of the importance of having an awareness of CT in order to be able to manage their reactions. As shown in Figure 2, therapists talked about attempting to hold awareness of their emotional experience, personal history, repeating patterns, their role and limitations as a therapist, and their self-state.

Awareness of Emotional Experiences

Therapists talked about the importance of being aware of, or "noticing," their emotional responses to clients. Noticing and acknowledging emotions was important because it enabled therapists to "give that some space" and "put that aside, say, in the moment, but then address that later" (Participant 12). Alternatively, they could choose to "get curious about it and notice it… play around with it and see where it went" (Participant 6). This choice depended on the circumstances, but could only be made once the therapist was aware of an emotional reaction. Therapists felt it was important not to "suppress" a CT reaction, but to decide on the most appropriate management strategy. Sometimes, being aware of an emotional response was enough for therapists to manage the reaction without needing to use further strategies. As Participant 12 said:

> Sometimes in a session, say, sadness comes up and that's completely understandable and reasonable. I don't have to necessarily unpack that any more than just acknowledge that. (Participant 12)

Awareness of Personal History

Second, several therapists talked about being aware of their own personal histories and how these could affect them. They believed it was important for therapists to recognise anything they are bringing into the therapy room that may affect the client or the therapeutic relationship. They should also be aware of anything that might trigger them within the session. As Participant 4 stated:

> We need to be able to work through that to see what pulls us in, what pushes us away, where are we afraid to go to with clients in our relationships because of our 'stuff'. Because we hinder our clients' growth when we're afraid to go places or we're too over-eager to go places because we might be just unaware.

Some therapists considered that CT reactions could be "very unhelpful" for clients if therapists had not "worked on and learned to be very mindful of" their CT (Participant 10). Conversely, it could be helpful for both clients and therapists' ability to work with them if therapists were able to be mindful of their own experiences and hold an insight into their triggers. This appeared particularly important with strong CT reactions related to therapists' own issues. This was reflected on by Participant 2, who talked about her own CT issues:

> The ones (CT experiences) that stand out for me probably stand out because there's so much of my own stuff involved … are ones that I think resonate with me on a kind of deeper level. And I'm not saying that all of the specifics that I'll share, you know, it's kind of like relate back to my own kind of experiences and stuff, because not all of them, it's not true for all of them. But it's just the thought that I had at that moment, was that sometimes the ones that stand out, it's because they trigger you so much, or it's close to home for you.

As well as their personal histories, some therapists thought it was important to be aware of their current circumstances. For instance, one therapist felt that once she had her own children, "it was going to be too, for me personally, too difficult to see babies in distress and to go home to my own little ones" (Participant 7). The awareness that "certain presentations or dynamics might be more challenging" (Participant 7) at the time was crucial. It allowed therapists to either be more selective about accepting clients that were too triggering, or to seek extra support beforehand.

Awareness of Repeating Patterns

Therapists believed that they needed to be aware of repeating emotional reactions. Repeated emotional responses to clients indicated to therapists that they may have been experiencing CT. Therapists sometimes experienced the same emotional responses to clients who were "quite different" (Participant 13). This suggested to therapists that the CT may be more related to their own personal histories. Therapists spoke of repeated emotional reactions to the same clients. They regarded this as a "big heads up" that they were experiencing CT (Participant 4). One therapist perceived this recurring emotional response as

a "signal to go, oh hang on, what's that about? What, what's, what's happening here?" (Participant 6).

Therapists also talked about recognising whether the therapeutic relationship was replicating their clients' other relationships, such as their relationships "with their partners, with their family, with their friends, with their workmates" (Participant 14). Clients sometimes "draw therapists into patterns replicating maybe relationship patterns experienced before" (Participant 5). These patterns were important for therapists to notice, as they could provide them with important information about their clients' interactional styles and relationship histories. One therapist felt that "growth" both for themselves and the client "can come from noticing these patterns" (Participant 6).

Awareness of the Role and its Limitations

Some therapists discussed the importance of attempting to maintain an awareness of their role as a therapist and its associated boundaries and limitations. These therapists felt that "being really aware of what we can or can't do in terms of creating some change" (Participant 12) was useful in easing CT reactions and reducing the impact of these outside the work environment. According to Participant 11 "it definitely makes it (CT) smaller because I know I'm doing everything within my role that I should be doing." Participant 14 agreed that "what I do with my client is what I can do with my client in the time … I feel like I've done the best I can at that time" (Participant 14).

Awareness of Self-State

The therapists thought that they needed to be aware of their self-state, for example, how tired, fragile or stressed they felt on a particular day. They believed that this influenced how "activated" they got in sessions, and how well they could "trust themselves" and their emotional responses (Participant 10). Therapists reflected that when they felt stressed or had a bad day, they could be "slower to attribute" CT to a client (Participant 6) and therefore might not be able to "withstand some of those more challenging projections or the dynamics that get evoked" (Participant 7). An awareness and acknowledgement of how therapists felt

on a particular day was therefore important to help understand their emotional reactions, and enabled them to "be quite present" and "manage the session quite well" (Participant 10).

Reflection

Once aware of a CT reaction, therapists spoke of the importance of personal reflection in understanding and managing this reaction further. This processing time was perceived as important because it was not always clear within sessions where the emotional response was coming from or what it meant. This was because there may be "a lot of high emotions or, you know, anger, hostility or high levels of distress, confusion … that makes it even harder to kind of figure out what's going on" (Participant 13). Through reflection, some therapists felt they were able to process the emotion, which made sessions with triggering clients easier. Furthermore, reflection helped them get to the "realisation" of what clients needed (Participant 1), to engage with clients better, and to "set me up for when I go into the next session" (Participant 13). Some therapists believed having some "reflective space" was helpful and enabled them to step back from interactions with their clients. This helped "make it less personal" (Participant 13). Initially, for many therapists, reflection involved taking "a moment to just sit quietly and just try to figure out what just did happen" (Participant 14), or experiencing "a moment of stillness in myself" (Participant 7). Some therapists found it useful to ask themselves questions during their reflection, for example:

> What was going on? Was this me? Was this a dynamic with the client? Was this something new, something old or something I've come across before with this client or with another client? (Participant 14)

However, some therapists observed that this reflective space did not always lead to "clarity. Sometimes you don't get an answer until a bit of time has passed" (Participant 14). However, they did not feel pressured to "make sense of it straight away" (Participant 5) and perceived that being patient and "holding the curiosity around what happened" (Participant 14) was important to help overcome a lack of clarity. One therapist noticed the personal effects when they had not sufficiently reflected. It emerged as "waking up in the night" which they felt was the mind's way of "hunting for reflective space" (Participant 10).

Theme Two: Pre-Session Management Strategies

As well as making space for reflection after sessions, therapists spoke of the usefulness of taking time before each session to "check in with yourself" (Participant 10). These therapists felt that this strategy was useful for their own self-regulation within sessions. As one participant said, this pre-session time allowed her to be "kind … respectful … encouraging of the client" in the session (Participant 12). Furthermore, therapists who took this break believed it enabled them to "be really present", which they "owe to the next person" (Participant 10). Participant 10 described how she used this pre-session time:

> Before you get to work, as you're walking to work, what sort of state am I in? What's been going on? And then before each session I actually, before I walk in I like to actually check in, do a bit of a body scan and check in with me, myself, because that, that is really important. And interestingly enough there are times when I've gone in and I've thought oh, I'm a bit fragile, I need to be really careful, and funnily enough I've actually been able to be quite present. And just because I've been able to acknowledge that to myself and manage the session quite well.

One therapist described using a pre-session mantra or practising phrases before sessions, particularly with challenging or triggering clients. This enabled her to mentally prepare and hold onto the "goals and visions and values" of the session (Participant 12). Another therapist thought that it was helpful to write down "and think about what it is that I want to talk about" (Participant 6) prior to sessions.

Theme Three: Within-Session Management Strategies

The therapists discussed strategies they engaged in during sessions to manage CT. These included breathing, slowing down, and making space for the CT response. Pausing or slowing down, taking a moment to gather their thoughts, and giving space to the emotion was thought to be beneficial to managing reactions that arose in sessions. Many therapists talked about using breathing strategies to achieve this, which could be done subtly. These therapists thought that taking a deep breath was helpful in settling and grounding themselves, principally when they noticed physiological responses and anxiety. This was particularly helpful if therapists believed it was not in a client's best interests to notice a reaction. Some therapists worried that if clients noticed their anxiety or distress, the clients may not "feel able to continue to be open and share with me" (Participant 1) or that it may

"divert away from something that really matters in the session" (Participant 10). Taking a moment of reflection or a deep breath was also thought by some therapists to be a useful way to regulate themselves emotionally within sessions, which helped them "sit alongside client distress" (Participant 8). Therapists thought that their ability to sit with their own and their clients' emotional distress was "containing" for clients and facilitated the therapeutic connection "alongside the sadness" (Participant 1). Participant 7 described how therapists could bring themselves back to being present at any point during the session:

> And so at any point in that process you can bring yourself back, if you have the ability. It might just be something that you do, or it might be a trigger that you can, you know, have for yourself … And yeah, so if I do have enough of a moment to be able to bring myself back I think that's really helpful to be able to do that. It might just be putting my feet both on the floor, sitting differently, being aware of my breathing. Just taking a moment before I respond, taking a breath even can be really helpful to, yeah my mind to come back in a way that's more centred, more thoughtful perhaps.

Alternatively, some therapists described overtly naming that they were taking a moment for themselves to clients. For instance, some therapists told their clients, "I just need a bit of time to collect myself here" (Participant 10), or "can I just take a second to think that through" (Participant 11), and "I'm noticing my mind is really fast trying to think of all these different ways I can help you. I wonder if I just need to actually slow down and take a minute" (Participant 1). This was observed to be helpful for therapists in achieving some reflective space within a session.

Theme Four: Utilising Countertransference

The majority of therapists talked about utilising their CT through naming and discussing their CT reaction with clients. Therapists felt that this strategy was sometimes helpful for them in managing their CT, and they also perceived that it could be helpful for clients and therapeutic relationships. Therapists had different ways of communicating their CT with clients. Some therapists directly told clients how they were feeling, such as Participant 14 who said, "I'm noticing that I'm feeling quite cross in hearing about what's happened" when working with adolescents who had been abused, particularly sexually abused. Similarly, when working with an anxious youth, Participant 11 commented to her client on her CT, "I'm feeling really anxious right now" and then explained to the client: "I am trying to figure out if

that is me or you? Are you feeling anxious?" One therapist used a slightly different approach to talk about her CT when working with an adolescent and their father. Although still direct, this therapist did not explicitly name her own reaction in the room. Instead, she drew on it to ask the client, "What happened for you when dad just said that? Because if I were you I'd be really irritated at that" (Participant 2). Other therapists use a gentler approach with language, such as "I'm noticing this, or I'm wondering, or I'm curious" (Participant 4). Alternatively, other therapists have talked about the feeling "in the room" (Participant 9) or made CT a "collective thing and say things just feel really hard, or really stuck" (Participant 9) with adolescents and families.

Many therapists reflected on how naming their CT with clients was dependent on circumstances, and was not a strategy that could be used with every client, family or therapy session. As one therapist said:

> There are points where you do need to be explicit and kind of address it, but I also think there are lots of points where you do just need to deal with it internally. Because you know our primary role is to be there for the client. And most of the time that involves different things. (Participant 9)

Whether therapists thought that being "explicit" about their CT would be beneficial was dependent on the client and the therapeutic relationship. To highlight this, one therapist said:

> It just really depends on the situation, it depends on the relationship with the client. How strong they are at that particular moment? Can they be challenged on something? It really depends on how the client is feeling, how you are feeling. How you articulate it. How sensitive the client is to it. (Participant 14)

One therapist always considered "how psychologically-minded my clients are" (Participant 8) when deciding whether to talk about her CT. Other therapists reflected on the "readiness" of clients and families to hear and discuss the therapist's reaction, as for some clients "to name that I think we would lose the relationship" (Participant 7). The majority of therapists thought that talking about CT in sessions was related to timing, and required a solid relationship. However, as Participant 4 reflected, the timing varies greatly between clients and the strength of the relationship is of more importance:

> There's no recipe for determining when that's going to be right in terms of, you know, A plus B equals C. Okay, now's the time to do it. It's all based on gauging the relationship and so what I learnt from that is, for her, what she needed was more time warming up into the relationship before I tried going there ... It's not time-bound because sometimes you can form relationships quite quickly. Yeah, so it is, it's about, you know, gauging it right, I guess, and also having the skills to repair it if you've got it wrong.

Therapists explained that naming CT was a more risky strategy, because "you have to be clear that you know why you're saying something because you're not, you have to be sure that it's not your stuff" (Participant 14). Therapists also had to consider whether this strategy aligned with the therapeutic modality and treatment goals.

Theme Five: The Importance of Supervision, Personal Therapy and Colleagues

Most of the therapists talked about the importance of having supports for processing, understanding and managing their CT reactions. This included supervisors, peers and colleagues. The importance of these supports was shared by Participant 7, who stated that "to do this work we have to feel well supported and well-resourced enough emotionally."

Supervision was helpful to all therapists to enable them to process their CT reactions and manage the impact of these on themselves, their clients and the therapeutic work. Therapists felt that with supervision, they were better able to formulate the clients' histories or behaviours that contributed to the CT experience. Through this formulation, therapists were then able to understand their reactions and to feel validated. Furthermore, some therapists observed that this formulation and "different insight" increased their empathy for clients (Participant 5) and their understanding of what the clients' therapeutic needs were. Participant 1 observed that with supervision, she was better able to "mini-formulate myself or my reactions" to understand where they came from and how they affected behaviour in the therapy space. Supervision therefore appeared to help therapists understand the origins of their CT reactions, including "what is mine and what is the child's" (Participant 4). Moreover, through talking about CT in supervision, one therapist noticed, "the feelings we experience dissipate so it suddenly becomes a whole lot less scary" (Participant 4).

Therapists observed the benefits of supervision from someone who was able to "consider a scenario dispassionately" (Participant 13). Supervisors had a tendency to hold a fresh perspective, and asked prompting questions, for example, "What was that like? What did you experience? Why didn't you do something, you know? Why didn't you open up that

avenue of assessment?" (Participant 3). Supervisors could also hear or notice things that the therapists might have missed, including their blind spots. This helped therapists "gain that insight which is then going to inform my work" (Participant 7). Therapists found supervision particularly helpful when a response felt unresolved, or "a bit foreign or larger or stronger than other feelings" (Participant 5). It also helped when therapists could not make sense of the CT themselves, or it lingered for a long time. While all therapists reflected on the importance of supervision, some spoke about the usefulness of specific supervision styles. They preferred supervision that was "reflective," "relational" and "looking at the process as opposed to the content" (Participant 10).

Another form of support therapists found useful for managing their CT was personal therapy. Most therapists spoke of having done their own therapy and how beneficial this had been to their personal and professional lives. Some therapists reflected that their own therapy experience helped them "figure out" their CT responses, including where reactions came from. This was because these therapists believed they "know their own stuff" (Participant 11) including their history and triggers. Other therapists felt that doing their own psychotherapy helped with "tuning down some of those automatic responses" (Participant 13) as well as strengthening their ongoing reflective ability. Some therapists discussed the benefits of ongoing personal therapy. They thought this was useful due to the "boundary between professional supervision and therapy" (Participant 9) whereby "deeper" or more personal discussions were "not appropriate for supervision" (Participant 4). Therefore, if a reaction was particularly personal or triggered by therapists' past experiences, personal therapy provided a place to process this. These therapists believed the combination of supervision and personal therapy worked effectively. As one therapist said, the two processes "dovetail each other to allow me to come the realisation of much more what is mine" (Participant 4).

Most therapists felt that talking with colleagues was hugely beneficial in managing CT reactions. Some therapists considered themselves fortunate to have a team where informal supervision could occur, such as phone calls or "corridor supervision" (Participant 10). Participant 10 described debriefs with fellow clinicians as "the gold in therapy" as it allowed CT reactions to be processed after a session when the emotion was still present, particularly as supervisors were not always accessible immediately after sessions. Even just "a rant and a rave to a colleague" enabled one therapist to feel as though her CT was "finished and it's left"

(Participant 11). Colleagues who were aware of therapists' weaknesses also allowed for open discussions where emotions could be processed.

Debriefing with colleagues could sometimes increase therapists' understanding of a CT response. For instance, "When we talk about the case, hearing about how it's presented or how it's impacting our colleague can give us other information that might be helpful to reflect" (Participant 7). Furthermore, some therapists were able to understand their CT further by exploring whether their colleagues had experienced similar reactions. When colleagues shared CT reaction, this suggested that the CT was more indicative of what the client was bringing. However, one therapist also warned of the danger of a shared CT response in that "it's hard not to externalise that and make it all about the client … So that we don't get into a dynamic where actually we're, what's the word, perpetuating something that's unhealthy" (Participant 7). Sharing in a reaction could however help therapists feel validated and reassured when they were critical of themselves, wondering if they "should be doing this better" (Participant 9). Conversely, different reactions to colleagues provided therapists with information that their CT may be more personal. This helped them to retain empathy for clients through recognising that the emotional response may not be "objectively true" (Participant 11).

Child and family work often involves co-therapy, where multiple therapists are involved in sessions. Therapists said the presence of co-workers was "holding," "supportive," and helped the therapist to "centre themselves" (Participants 7, 8 and 9). Co-workers also offered emotional safety, in that therapists were more able to withstand client emotions, particularly anger. Furthermore, some therapists, such as Participant 10, felt that having a colleague "attuned" to them in the room enabled them to use other management strategies, as the colleague "could see that I was actually really struggling to manage … and so she just kind of took over for a little while to give me time to regulate". As Participant 7 reflected, "I feel like I've got somebody with me in on this together, that we can both be a unit together to help, to hold the enormity of what the client is bringing." Co-working in child and family work can also involve different therapists working with different family members, supporting one another towards the same therapeutic goal. This could lead to quite different CT reactions amongst colleagues, because "you need to have someone who's more aligned with the parents because that, that really facilitates that work. And you need to have someone who's more aligned with the child" (Participant 8). When this occurred, therapists need to "keep

talking so that we're unified in the way that we're working together, because there could be the potential, yeah, for that dynamic to become quite divisive" (Participant 7).

Compared to individual adult therapy, many therapists observed that there was greater support for therapists working with children and families through colleagues and supervision processes. Not only was there greater room for co-working, but therapists observed that CT was also discussed more amongst colleagues who work with children and families because the "emotion can fly around" and was shared amongst clinicians. Participant 14 reflected that in adult work, the "clinician would talk to their supervisor, but there doesn't tend to be the same sharing of discussion around the dynamic of a family as there is in child adolescent services." Therapists also thought that supervision in child and family work was more reflective and relational because family, particularly infant, work is "so strongly focused in the relationship" (Participant 10).

Influences on the Management of Countertransference

As the length of therapists' experience increased, so did their "awareness, recognition and ability to kind of manage it" (Participant 13). Some therapists reported they were less effective at managing CT earlier in their careers because they were not familiar with which management strategies were more useful. There was also a greater reluctance to bring up CT in supervision. They thought this could be because they were struggling with feelings of incompetency and trying to prove themselves, and feared they might be "seen as unethical or failing already" (Participant 4). Later in their careers, some therapists noticed more room within therapy to notice CT because they were not focusing so much on "the next thing you're going to say" (Participant 8). This also meant therapists were more confident to use their CT to guide the therapeutic process.

The number and complexity of clients on their caseload affected therapists' ability to manage CT. Therapists observed that having a high number of clients in one day resulted in limited reflective time, so they were left with unprocessed CT at the end of the day, or needed to find additional space and time for reflection. A high caseload also affected supervision and the ability of therapists to process CT with a supervisor. As there were many clients to discuss, some therapists observed that supervision remained content, rather than process, focused.

Summary

Therapists spoke about the range of strategies they used for managing their CT towards children and families. Many therapists thought that it was important to maintain awareness of CT, as well as their personal experiences and state on a given day. They thought it was important to allow themselves the time to reflect and process their reactions after session. During sessions, therapists described strategies they used to manage immediate emotional responses, including breathing, slowing down and grounding themselves. All therapists described talking with others, in the form of supervision, personal therapy or with colleagues, as helpful in managing and understanding CT reactions. Therapists also talked about utilising CT, by naming and discussing their emotional responses with clients, if they thought that this would be therapeutically beneficial to clients.

Thematic Analysis: Therapist Perceptions of the Impact of Countertransference

This section presents the results of the thematic analysis of data related to therapists' perceptions of the impact of CT. Therapists were asked about their experiences of how CT affected the therapeutic process, relationship and outcomes. Therapists were asked to reflect on times they had been aware of and managed a CT reaction, as well as times they had experienced difficulty managing a reaction. Therapists spoke of positive and negative impacts of CT, including on themselves, their clients, their therapeutic relationships and therapeutic outcomes.

This thematic analysis is presented as two broad themes: *Successful Management of Countertransference* and *Unmanaged Countertransference*. The data for *Successful Management of CT* is presented as four subthemes: *Clinical Decision Making, Benefits for Clients, Benefits for Therapists* and *Benefits for the Therapeutic Relationship.*

Theme One: Successful Management of Countertransference

Clinical Decision Making

Therapists spoke of the positive impacts of managing and utilising CT on their clinical decision-making including formulation, the content of the sessions, and other practical decisions. As discussed previously, most therapists thought that CT reactions provided information about "myself, about the client, about the dynamic between us, the relationship" which could be used to inform the work (Participant 7).

CT reactions provided some therapists with insight into their clients' internal experiences, particularly when the therapists perceived themselves to be mirroring how the client was feeling. These therapists believed this helped them understand their clients' needs, and how best to proceed with therapy. For instance, one therapist mirrored a family's anxiety and then reflected on her learning of this CT response. She described how "whenever I feel anxiety and overwhelmed by a family's crisis, I've learnt that it's, it's very often the parents' anxiety about wanting a quick fix" (Participant 2). This therapist used this understanding to advise the parents "that there's no quick fix", and to encourage and support them on their therapeutic journey. Another therapist spoke about her own "CT of feeling intruded on" by a

mother's questions. This therapist thought the client may have "felt bombarded by intrusive questions" from the therapist. She was able to apply this potential insight and be "a little bit more gentle" in the future (Participant 7).

Some therapists also talked about their experiences of mirroring children's feelings in response to their parents. They felt that this mirroring was "helpful to tap into" (Participant 9) in order to better understand the dynamic between parents and children and therefore provide ideas about what therapeutic work would be useful for the parent-child relationship. For instance, one therapist reflected on a time she was working with a child and the child's foster parents. The therapist shared the child's emotions of feeling lonely, sad and unheard by the parents, and used this reaction to communicate to the parents:

> My countertransference was very much a feeling of a significant amount of sadness that's his, it is his through and through. And it was an extremely hard task to communicate that to parents 'cause they were essentially saying fix him. We wanna know what's wrong, and so I sat them down, I was brutally honest. I said well, you know this is what's wrong, he's wanting more time with you. He is, he is feeling like you're criticising him all the time. And, you know there was a very hard conversation and I drew on my own countertransference to really amplify what he had been experiencing. Because family wouldn't talk to each other, so how else would they know how he feels. The outcome of that has been that parents have listened.

Similarly, Participant 11 recalled her CT when working with a family regarding behaviour change in a child. The therapist reported feeling incompetent due to criticism about lack of change from the parents, and so attempted to prove her knowledge through educating and "trying to be clever." However, once the therapist noticed her CT reaction, she was able to shift towards listening and validation. She shared her learning about CT from this experience, "how you want the parent to treat the child, you need to treat the parent." Participant 11 described this process and its outcome:

> And I think that, well my theory is, because they were experiencing validation from me about how hard it was without me trying to educate and change. It means that they were able to give their kid validation without trying to educate and change. And so just as I was seeing them, they were then able to see their kid. That was really powerful, and I discharged quite soon after that.

One therapist also recalled a time when her CT may have reflected a young person's previous experiences of abuse. The therapist perceived the CT as potential "insight, perhaps into kind of her world and her experiences, but perhaps also how she uses relationships to

kind of control or to feel more kind of safe" (Participant 5). Other therapists spoke about their desire to rescue CT response as being particularly important in guiding clinical decision-making and therapy. These therapists used their CT to help clients, particularly children, "take more control for themselves" (Participant 12) and to learn to rescue themselves, as outlined by Participant 4:

> The thing that we have to learn to do in life is to rescue ourselves. And so the more that I can empower the children and the young people that I work with to learn how to seek appropriate support, to learn how they can take steps towards getting where they want to go rather than hoping that someone else will come in and rescue them, sets them up to rescue themselves. And they are always going to be a better rescuer of themselves than anyone else ever can be.

Finally, some therapists thought that insight into their CT helped with practical decision-making. These decisions included whether therapists felt able to effectively work with particular clients or whether to discharge them. Therapists thought that their CT influenced the frequency with which they saw clients, and whether to take a more patient "wait this out in a supportive way" approach, versus "actively intervening" (Participant 3).

Benefits for Clients

All of the therapists felt that awareness and management of CT led to positive outcomes for children, adolescents and their families. In particular, the utilisation of CT was a valuable "therapeutic tool around validation" for clients (Participant 14). Several therapists believed naming their CT was a way of validating a young person's emotional experience in front of their parents. Awareness of their own CT helped therapists normalise a young person's feelings. It enabled them to say such things as "hey, what happened for you when dad just said that? Because if I were you I'd be really irritated at that" (Participant 2). Therapists thought that this showed the young person that they "have the right to feel the way I'm feeling" and that the therapist was on their "team" (Participant 2). Therapists observed that this normalisation and support "empowered" clients to communicate this feeling themselves (Participant 4). Some therapists utilised their CT to normalise and validate parents' experiences. Therapist 12 reflected on her experience of parenting with parent clients to "normalise the struggles" that can occur with parenting, and provided positive feedback and encouragement. These therapists observed that this CT reflection helped

parents feel "less anxious and calmer" (Participant 12) as well as "more understood and heard" (Participant 10).

Therapists perceived the utilisation of CT provided some parents with "new information" about how a child was feeling (Participant 14). Sometimes, if parents were not aware of how their child was feeling, the therapist's verbalisation of their CT allowed a "new understanding" (Participant 14) to be discussed in a way the parents had not considered. This was particularly helpful if the child was unable to explain or articulate their internal state themselves. Moreover, some therapists thought that parents might believe the emotional experience was more "credible" or "valid" coming from the therapist (Participant 14). Furthermore, therapists felt that utilising their CT was useful for role modelling to clients how to be self-aware and express themselves verbally (Participant 11). By naming CT with clients, therapists believed that they provided clients with a model of how to do this stuff with other people, such as their partner, parent or boss. By demonstrating how to identify and communicate emotions, therapists also taught the skills of problem-solving and emotional management. Participant 4 also thought that role modelling discussing CT taught clients "how to be vulnerable with someone" and that "closeness develops" as a result.

Participant 10 talked about using her CT to "facilitate reparation work" amongst family members. This therapist talked about using her own experience of discomfort during a session between a parent and teenager to facilitate repair work and role model how to talk about difficult family dynamics that occurred in session more effectively. This therapist saw this as an opportunity since "learning reparation in a therapeutic arena can be sometimes the first time our clients can ever have the chance to do that" (Participant 10). Another therapist felt utilising CT was useful for de-escalation. He observed that discussing his reaction with clients was "surprisingly effective in helping to bring the heat down" as clients had the opportunity to "pause" and appreciate what is happening in the room (Participant 13)

Finally, one therapist thought that discussing CT was important as clients may feel unable to identify or name the emotional experience for themselves. Through talking about the therapist's CT, clients can be "really relieved that they could talk about it, like they felt like it was just something that, wasn't something they could bring up" (Participant 6).

Benefits for Therapists

The majority of therapists discussed positive outcomes they had experienced from the management of their CT. Therapists reported that being aware of and managing their CT responses helped them to retain empathy for themselves, clients and co-workers, and be "much more compassionate and kind and patient and gentle with the process" (Participant 12). Several therapists felt that utilising CT allowed them to process emotions with clients, and enabled emotions to be released. This was cathartic for therapists, and helped them to feel more connected to the client because they were "sharing in that vulnerability" (Participant 4).

Some therapists talked about how managing their CT responses in sessions, such as through breathing, helped them to "sit alongside" their clients' emotions (Participant 1). For some therapists, being aware of their CT enabled them to maintain "objectivity and clarity" (Participant 7) about the dynamics being evoked. This enabled them to "manage their boundaries" more effectively with clients (Participant 12).

Finally, one therapist spoke about the power of reflecting on CT. This therapist felt that through reflection "we find that the feelings we experience dissipate so it suddenly becomes a whole lot less scary … you realise that the feelings that you either acquire or are given, in response to your clients, aren't that bad" (Participant 4). Participant 11 highlighted the significance of managing CT:

> It's just so much better. It's better for the therapeutic process but it's also so much better for my own wellbeing. It feels like I'm set free. It helps me put in boundaries between work and me. And to sort of release me from stuff or put back in power what is my power. It feels quite liberating to do it in terms of the therapy process. For the therapy and for me as a person and as a professional.

As mentioned previously, therapists who managed their CT by taking it to supervision felt validated in their reactions to clients and reassured that "this isn't necessarily because of me not doing my job well enough" (Participant 13). Supervision also helped make the reaction "less personal" for some therapists.

Benefits for the Therapeutic Relationship

Most therapists talked about how managing and utilising their CT was effective in strengthening the therapeutic relationship. When therapists thought it would be beneficial, they observed that naming their CT with clients created closeness in the therapeutic relationship. They felt that this was because "Most people really appreciate that level of honesty because you're attuning to them" (Participant 4). Through sharing their emotional response, therapists believed this helped with "engagement" and "trust" as clients saw the therapists as "human" (Participant 13). This reduced the fear and anxiety that some people experienced when seeing a clinician. Participant 2 reflected on the importance of CT in therapeutic relationships:

> It's a therapeutic relationship, but, I mean we know that relationship building thing is the most significant therapeutic outcome mediator. So in many ways I think that's (CT) the fancy words for the hard work that needs to be done to build and maintain that relationship, which is, which calls for honesty. And naming it, and working through it, otherwise it's not an authentic relationship.

Some therapists thought that honesty and transparency about their emotional responses were particularly helpful with young people. This was because some young people expected therapists to be just another adult who would tell them what to do. One therapist found that articulating their feelings of being "useless" or "flummoxed" in those moments appealed to young people and resulted in more engagement as they "like to contribute to that" (Participant 13). Therapists also thought that talking about their CT with clients levelled the power imbalance because it demonstrated that the therapist was "joining in the relationship and saying, you know, this is a relationship, I'm not unaffected by you" (Participant 4).

One therapist talked about the benefits of managing their CT response in session on the therapeutic relationship:

> That then will give the client the message that I can tolerate their distress and not be swamped. Because I think for a client sometimes it's so unconscious and so powerful for them, their own reaction or their response takes them by surprise. And to have somebody who can withstand that, and sit with it, and stay in the relationship can be incredibly powerful. And that's not a really massive, you know, profound thing that I'm doing necessarily but on another

> level I think it will give the client the message that actually I'm here for you, I'm still in this relationship and we can work with this together. (Participant 7)

By being aware of, and making space for CT this therapist was able to centre herself and emotionally regulate, and therefore be there for the client in a calm, compassionate and trustworthy way that was important for the client and therapeutic relationship.

Therapists therefore spoke of the overwhelmingly positive effects they perceived that managing and utilising CT had for themselves, their clients and the therapeutic relationship. However, there were also instances where therapists had difficulty managing their CT with clients. The following section examines when therapists found it difficult to manage their CT, and the effect they perceived this to have on the therapeutic process and outcomes.

Theme Two: Unmanaged Countertransference

Therapists reflected on times they had experienced difficulty managing a CT reaction. The main causes were a lack of awareness of their CT response, a lack of awareness of how their own personal histories were contributing to the CT, or from unmanaged emotion during the session. These unmanaged reactions had negative outcomes for the clients, therapists and therapeutic relationships.

Sometimes therapists felt they had not managed an emotional response effectively during sessions with clients. For one therapist, this resulted in her "ending the session earlier than scheduled" (Participant 1) due to feeling frustrated during the session. Conversely, another therapist spoke about proceeding with therapy longer than she should have, because she felt "desperate" to help and make change for the client (Participant 6). However, she thought that the ongoing therapy "possibly contributed to her sense of hopelessness". Other therapists observed the impact of unmanaged anxiety and anger on their response to clients. Due to a high level of anxiety about needing to "get back control" of the situation, Participant 13 thought that he had been "much more assertive" than normal and "more restrictive in my plan." He reflected that this had been "unnecessary" and led to both the therapist and the client feeling "terrible." Participant 5 became angry during a session, which the client "could feel." Consequently, the client walked out of the session.

Clients also felt these unmanaged CT reactions over the phone. One therapist spoke of sounding "a bit too relieved on the phone" (Participant 14) when a challenging client called

to cancel, and not calling them back to reschedule quickly enough due to her CT response. These unmanaged reactions interfered with engagement and caused a "rupture in the relationship" (Participant 14). The therapeutic alliance was often be hard to rebuild following this rupture, as it "can take quite a bit of time to rebuild that trust" (Participant 7).

Unmanaged CT made the therapeutic process "much more difficult" for some therapists, as they felt "less able to pull on that empathy" that was usually accessible (Participant 8). Being unaware of and therefore not managing CT was also observed by some therapists to result in feeling stuck in therapy. When therapists did not use their CT to understand the client or its relationship to the therapeutic process, they ended up "sitting with the status quo" (Participant 4) and unable to "make much difference" (Participant 6) to the client's goals and functioning.

Some therapists reflected on times they were not aware of how their own personal experiences were contributing to their CT. Although these CT experiences were individual to therapists, many therapists thought that if they were not aware of their own histories and sensitivities, they had the potential to "lose perspective" or "act out your own attachment history" (Participant 8). For Participant 1, her personal CT resulted in "higher expectations of a mother's abilities to handle and cope with stress." Another therapist was particularly triggered by a scenario that related to her past, which if unresolved could have "negatively impacted" the relationship with the parents. Therapists thought that an awareness of how their personal histories contributed to the CT was particularly important when there was a shared response with a colleague. If therapists were not aware of their own contribution to the shared CT, this could lead to a "blaming" dynamic in which therapists could "lose sight" about how this information informed the therapy (Participant 7).

Several therapists talked about the negative impact of over-identifying with clients. Over-identifying could occur for therapists when they found a personal connection with a client or their story, and the therapist did not notice or manage the emotions aroused by this connection. Therapists thought that over-identifying with clients carried the risk of making assumptions about a client's history, feelings and therapeutic needs. This could result in "pushing the clients into pathways" (Participant 4) which might be irrelevant or inappropriate, based on the therapist's history and needs rather than the client's needs. Making assumptions meant that Participant 6 overlooked the "complexity in the system and complexity in her behaviour towards other people." Over-identifying could also lead to the therapist feeling "far

more useful than you really are" (Participant 10). This could limit the amount of reflection, formulation or supervision therapists sought for their clients. An example of over-identifying with a child was when a therapist used the therapeutic process to address their own needs, rather than the child's:

> That invites you into seeing the client almost as yourself and you're in there healing yourself, yeah, with the client. And I think that's a very important thing to be aware of, that, because that's huge, because then you are not only a healing trajectory for the child, you're on an attempt to heal your own stuff through that child, which isn't going to work for you either. (Participant 4)

Over-identifying with clients could feel "familiar or positive or comfortable" (Participant 9), which made the therapeutic process "more enjoyable" (Participant 10) and "less effort" (Participant 9) at times. However, one therapist warned that it was just as important to manage these reactions as other more negative ones, and be "really boundaried and professional" (Participant 10).

Participant 10 spoke about the impact unmanaged CT once had on her personally. She described becoming so "activated" while working with a parent that she was dreaming about the client and waking during the night, as her mind and body was "hunting for that reflective space." This therapist thought in retrospect that she needed to "notice my feelings with far more compassion" as disregarding the CT was "doing me no good physically or emotionally or anything else" (Participant 10).

Summary

In summary, therapists described the impacts that CT had on the therapeutic process with children and families. Therapists spoke about the overwhelmingly positive impact that managing CT had for clients, themselves and the therapeutic relationship. Awareness, reflection and talking about CT with others helped therapists with clinical decision-making, formulation and therapy planning as they gained greater insight into the clients and their own internal experiences. Managing and utilising CT was also identified by many therapists as a tool for validation, normalisation, role modelling and facilitating important discussions with clients. Some therapists also identified the impact of not being aware of, managing or utilising

their CT with clients. They spoke about how this led to ending sessions or withdrawal of clients, rupturing the therapeutic relationship and a lack of sleep.

Thematic Analysis: Therapists' Recommendations for Training and Supervision

As noted earlier, therapists were asked to reflect on their training and supervision experiences, and to provide recommendations for future therapists. Four themes emerged from the data. These were *Avoiding Discussion of Countertransference, Personal Therapy, Supervision,* and *Training*.

Theme One: Avoiding Discussion of Countertransference

Some therapists felt that the culture of CT, particularly in New Zealand, was one of silence and resistance towards the notion of CT, which hindered discussion of these therapist reactions. Therapists thought that this may come from the unrealistic expectation of therapists to "have no feelings" and "never be anything but explicitly objective" (Participant 11). This "weird expectation" that therapists are not impacted by the work they do has led to experiences of "instant shut down" (Participant 9) for some therapists when they tried to discuss CT with others. Other therapists felt the need to keep their CT a secret, due to the feelings "layered on top of shame and guilt" (Participant 4). One therapist believed that "we need to create a culture of safety" so therapists will feel "brave" enough to talk about their CT with other clinicians (Participant 4). This "culture of safety" needs to come from the acknowledgement that therapists have emotional reactions in their work, and also have "issues and challenges" and should be "allowed to make mistakes" (Participant 6). Some therapists who had trained or worked overseas felt the conversations around CT in New Zealand have been limited and that CT is downplayed. One therapist reported, "it doesn't seem to be a thing we talk about in New Zealand" (Participant 4).

Additionally, some therapists thought that both within New Zealand and internationally, there is no "shared language" for talking about CT, which has limited therapists' ability to have discussions with others. One therapist suggested that we need a

better "framework in language … everyone would agree that this stuff happens" but they do not know how to talk about it (Participant 9).

Theme Two: Personal Therapy

As mentioned earlier, many therapists spoke about the importance of personal therapy. Therapists' thought that personal therapy was useful in learning how their own history "has impacted them, strengthened them" (Participant 10). It was also useful "to explore who you are and how that plays a part in the therapy room" (Participant 4). Many of the therapists who had experienced their own personal therapy felt that this experience helped them to be more "open to emotional experiences," to turn down "automatic reactions" (Participant 13) and to understand themselves better personally and professionally. Some therapists thought that personal therapy was so important, that it should be included within psychology training programmes, either as a requirement of the programme or by providing access to free or subsidised therapy. For instance, Participant 12 stated:

> I think clinical psychology's a little bit behind in that respect. That we should actually be making that a requirement of the programme, because if people aren't willing to go and see a counsellor or a psychologist then you're in the wrong job.

Personal therapy was also thought by some therapists to be important beyond the individual therapist. Without personal therapy, we will continue to maintain a culture of silence around CT, as therapists will not have the awareness to have discussions around it. As Participant 5 said:

> It is near impossible to discuss or identify or use CT if you haven't had it with somebody in a therapeutic relationship … It's an experience, an experience that you're getting and you can only really get trained in it if you've experienced it in your own therapy.

Theme Three: Supervision

As mentioned earlier, the majority of therapists spoke about the importance of supervision for managing CT. Therapists thought that the ability of supervisors to discuss CT varied and depended on the supervisors' training and supervision style. They also thought

that the benefits of supervision for CT were dependent on whether the supervisors had "done their own work" in regards to personal therapy (Participant 4). Several of the therapists found supervision that was "reflective and relational" and that explored the "process as opposed to the content" (Participant 10) as helpful. Some commented that psychoanalysts were particularly useful as supervisors in discussing CT, as it is their "norm, their bread and butter" (Participant 4).

Based on their experiences, some therapists provided recommendations for supervisors in order to create a safe environment for therapists that allow for the discussion of CT. Primarily, therapists thought that supervisors should "lead by example by talking about situations where I've had counter-transference and this is how we resolved it" (Participant 11). This role modelling is important as it creates a "safe place" for supervisees to bring their CT up, and "relaxes" them to the expectation that CT will happen and "there's nothing wrong with it" (Participant 4). Moreover, therapists thought that supervisors should be explicit in saying to supervisees "this is likely to happen to you … and here's what you can do with it" (Participant 6). This is because discussing and managing CT are skills that need to be taught. Finally, one therapist believed that the focus for supervision training should be to help clinicians help supervisees to "attend to reactions that they might be having in a room" (Participant 14).

Some therapists also thought that group supervision or "processing groups" (Participant 10) could be helpful to reflecting on CT. This is because "team CT" could be different to individual CT because teams could create "shared narratives" about clients (Participant 1). However, group supervision needs to help members remain aware of the part they are playing in the CT reaction, so the CT is not "externalised" and made "all about the client" (Participant 7).

Theme Four: Training

Many therapists reported that discussion and learning about CT within psychology training programmes is limited. Some reflected that this may be because training programmes are assessment heavy and focus on interventions such as cognitive behavioural therapy (CBT), which some therapists reported to be "theoretical" and "intellectual" as opposed to the "reality of what it means with a client" (Participant 14). As "therapy is all about relationships"

(Participant 14) several therapists believed that CT should be more integrated into the training.

The most consistent recommendation for training programmes was to address the culture of CT through discussion and staff role modelling. Therapists thought staff should encourage a culture of "humanity" with the message that emotional responses are normal and "you've got nothing to be ashamed of" (Participant 6). This could mean discussing the range of experiences that can occur and allowing staff to talk to their own experiences. Participant 11 said that her "number one wish from training" is to "smash this delusion that psychologists have all the answers, and that we don't have issues and challenges." Other recommendations therapists made for training programmes included more opportunities to "role play and practice" what therapists do with CT in the room (Participant 14), and to have a greater focus on teaching management strategies. Post university training lacks training for CT. Therapists said some trainings touched on it but by and large therapists have noticed a significant lack of opportunity to develop in the area of CT, with most having never attended a CT specific training.

Summary

In summary, therapists discussed their personal recommendations for training and supervision based on their own experiences of working therapeutically with children and families. Many therapists focused on the overall culture of CT, particularly in the New Zealand context, and how addressing this is important to making change and advance our knowledge about and use of CT. Other therapists made specific recommendations for supervision and training programmes, which focused on the role modelling of staff and supervisors. Finally, personal therapy was recommended by many therapists, in order for therapists to get to know themselves better personally and professionally.

Chapter Five - Discussion

This qualitative thesis study examined therapists' experiences and conceptualisations of CT when working with children and families. In particular, it sought to investigate the situations that trigger CT for therapists in child and family therapy and the nature of these CT reactions. It also aimed to develop an in-depth understanding of the impact of CT reactions on therapists and their clients, the therapeutic relationship and therapeutic outcomes, as well as the strategies that therapists used to manage their CT reactions.

The majority of the therapists in this study were clinical psychologists who had completed their training in New Zealand. Most of the therapists were using CBT and related therapies when working with children and families, which may reflect the predominance of these treatments in New Zealand training programmes (Kazantzis & Munro, 2011). The results of the thematic analysis suggest that therapists experienced a wide range of CT reactions in response to different triggers, and that they used and managed these reactions in a number of ways. Therapists reported different impacts that their CT had, when both managed and unmanaged. This chapter addresses these findings in the context of the existing literature, including research and clinical writings. This is followed by a discussion of the implications of the results, limitations and future research directions.

Triggers of Countertransference in Child and Family Therapy and the Nature of these Reactions

The therapists in this study reported a range of CT reactions that were triggered by particular child and/or family behaviours and therapy situations. Five overarching triggers of CT were identified through thematic analysis: *When Parents are Critical and Angry, When Families want Help but Disregard Therapists' Input, When Children are or have been at Serious Risk, When Families Lack Resources,* and *Being Friendly or Idealising the Therapist*. The findings are discussed in relation to research and clinical writings that examine therapists' CT with children and families.

Many therapists in the current study supported previous suggestions that CT reactions are more prevalent in family work compared to individual work (Dubé & Normandin, 1999;

Gabel & Bemporad, 1994; Gehlert et al., 2014; Friedlander et al., 2006). Clinical writings suggest that CT reactions are more common in family work because there are more individuals and relationships involved that can activate the CT (Gehlert et al., 2014). Indeed, therapists in this study reported CT in response to each individual, sub-system and the family system as whole. In particular, therapists often reported CT in response to parent-child relationships, which are not witnessed directly in individual therapy. Moreover, therapists felt that working with children and their parents elicited their own childhood experiences, their experiences of being parented and of parenting. In comparison, they felt that their personal issues were more frequently triggered in child and family therapy compared to individual therapy.

Therapists in this study also supported suggestions that CT reactions are stronger when working with children than with adults. Clinical literature suggests that these stronger reactions occur as a result of children's characteristics such as their directness and use of behaviour to communicate (Gil & Rubin, 2005; Kohrman et al., 1971), as well as children's greater demand for immediate gratification, their highly charged emotions and their unpredictability. These characteristics can force therapists to be more actively involved in the process, which can hinder therapists' ability to self-monitor their reactions (Dubé & Normandin, 1999). Children's vulnerability, powerlessness and dependency also added to the sense of responsibility to create change. This demonstrates the importance of understanding and managing CT for family therapists and researchers.

The particular triggers and nature of these CT reactions are now discussed in the context of existing literature on therapists' experiences of CT, both within individual and family work.

When Parents are Critical and Angry

The majority of therapists in this study recalled experiencing negative CT reactions when working with angry, critical, shaming or invalidating parents. Anger and criticism directed towards children typically led therapists to feel frustrated and angry with parents who did not appear notice the negative effect they were having on their children, such as the children shutting down or feeling unsafe or worthless. Some therapists felt angry towards parents who were unable to support children or responded in ways therapists deemed

inappropriate. Some therapists additionally felt protective towards the children or anxious about the unpredictability of parents. Clinical writings (e.g., Bonovitz, 2009; Scholfield-MacNab, 1989; Springer, 1991; Wallerstein, 1990) and research (Hay et al., 2019) consistently suggest that therapists experience combined feelings of protectiveness towards children and anger towards parents in these types of situations.

On the other hand, parental anger and criticism directed towards therapists resulted in CT responses of discomfort, anxiety and/or feelings of incompetence. Some therapists reported CT behaviours such as becoming more assertive than necessary in order to try and take back control if these emotions were not managed. This finding is similar to that of Hay et al. (2019) who found participants felt frustrated and afraid of clients displaying confrontational, intimidating or angry behaviour. In addition to previous research, the therapists in this study also reported sometimes feeling empathetic and understanding of angry parents who themselves had not received supportive parenting as children. They also had some empathy when they perceived that the parental anger came from concern for the child. This suggests that increased understanding of parents' experiences and parental anger can transform therapist CT responses from anger and frustration into empathy and understanding, which in turn may support the therapy processes.

When Families want Help but Disregard Therapists' Input

Therapists in this study experienced strong CT reactions in response to families who appeared to disregard their recommendations and failed to make meaningful therapeutic change, especially when there appeared to be a clear solution to the problem. Therapists observed three reasons that parents appeared to have for opposing their input. These included parents lacking insight or a sense of responsibility for the child or family's problem, engaging in enabling or self-defeating patterns of behaviour, and parents who appeared to be narcissistic or have a sense of entitlement. CT in response to clients who do not make therapeutic progress in individual therapy is discussed in a number of studies, both with adults (Cartwright et al., 2014; Linn-Walton & Pardasani, 2014) and with adolescents (Aradas et al., 2019). Therapists in these studies reported feelings of responsibility and blame (Aradas et al., 2019), helplessness and inadequacy (Cartwright et al., 2014) and dislike (Linn-Walton &

Pardasani, 2014) when individuals did not make adequate progress. This trigger and CT manifestation has not yet been explored in family therapy.

The therapists in this study felt frustrated in response to parents who had minimal insight into their role in the family's dysfunction. They found it frustrating when parents blamed children for a problem but did not acknowledge or accept their own role in the dysfunction. This lack of parental insight prevented meaningful change occurring, as the parents did not take on board therapeutic suggestions that could assist with the problems. This is a novel finding within the family therapy field; however, it aligns with adult CT literature that found therapists experience negative CT when individual clients lack insight or self-awareness (Linn-Walton & Pardasani, 2014).

Therapists in this study described feeling frustrated, stuck and hopeless when working with families who displayed enabling and self-defeating patterns of behavior and rejected their input and recommendations despite persistently asking for help and support. This CT reaction is similar to that discussed in Cartwright et al. (2014), in which therapists felt frustrated in response to client resistance to therapy. Some therapists were then concerned that their feelings of hopelessness about achieving change could contribute to an unhelpful dynamic, suggesting that CT behaviours may have been occurring. Finally, in response to parents who appeared narcissistic in the way that they believed to know better than the therapist, therapists reported feelings of anger and incompetence. If unmanaged, these CT emotions could also lead to CT behaviours such as telling clients off, which occurred for one therapist. Again, this finding aligns with Linn-Walton and Pardasani (2014) who found therapists reported negative CT in response to individual clients therapists perceived as narcissistic. This study adds to the research findings of Linn-Walton and Pardasani (2014) by examining the specific negative CT reaction and reason for dislike of narcissistic clients or those that lack insight. The results of this study suggest that these situations manifest primarily as frustration in response to lack of insight, and anger and incompetence in response to narcissism.

When Children are or have been at Serious Risk

Client suicidal ideation and suicidal behaviours tend to evoke intense feelings in therapists (Richards, 2000). Therapists in this study described CT reactions of anxiety and a

sense of responsibility in response to clients', particularly adolescents, suicidal ideation, self-injurious behaviours or risk-taking behaviours. Some therapists spoke about the heavy weight they placed on themselves in these circumstances. Some therapists recalled finding these emotional reactions too difficult to manage in sessions with clients by themselves and temporarily left sessions in order to seek collegial support. These CT reactions were particularly strong for therapists when there was a personal component, such as knowing someone who had died by suicide. Several research studies (e.g., Biggs, 2003; Ingley-Cook, 2019) have also found that feeling anxious and responsible are common responses for therapists working with risk and suicidality.

Working with children who present with abuse histories can also bring up strong feelings for therapists (Biggs, 2003; Ingley-Cook, 2019, Shevade et al., 2011). Therapists in the current study reported feeling sadness, anger, frustration, despair and distress for children who had experienced abuse or neglect and were suffering as a consequence of that trauma. For some therapists, this resulted in urges to cross boundaries in order to rescue, protect or care for the child. Therapists' reactions of sadness and the desire to rescue children in response to hearing about trauma and abuse is well-established in research (Biggs, 2003; Ingley-Cook, 2019) and clinical writings (Carr, 1989; Shay, 1992;). In fact, a desire to protect is suggested to be the principal CT reaction for therapists working with children (Bonovitz, 2009; Scholfield-MacNab, 1989). None of the therapists in this study reported acting upon their CT reactions to cross boundaries and behave outside of their role; however, working with children and families where abuse has occurred did appear to result in a strong pull to engage in CT behaviours.

Anger has also been found to be a common reaction amongst therapists working with children who have been abused and neglected (Biggs, 2003; Shevade et al., 2011). Therapists in the current study felt angry in response to the systems surrounding children that placed them in vulnerable positions, such as exposure to abuse. This aligns with the findings of Biggs (2003) and Shevade et al. (2011) who found that anger manifested towards the wider systems around traumatised children or to decisions being made that were not in the best interests of the children. Some therapists in this study reflected on the strong ache they experienced in response to child neglect, a finding that aligns with Biggs (2003).

When Families Lack Resources

Therapists in this study described CT reactions including frustration and sadness when working with parental mental health difficulties and socially isolated families. These triggering family situations appear unique to the current study with no previous findings in this area. Therapists reported CT in response to the negative impact of parents' own mental health challenges on the child and family functioning. In particular, therapists felt frustrated by parents who were triggered by their children or who were unable to be there for their children due to their own distress. Moreover, the need for parents to address their own mental health needs before the parent-child relationship or family functioning could be targeted was a barrier to the therapeutic progress. Therapists in the current study felt frustrated and sad that they were unable to support change in the parent-child relationship and in watching parental experiences replay for the child. These emotional responses sometimes led to CT behaviours, such as allowing parents to use family sessions to address their own individual needs, or taking care of the parents. For instance, one therapist reported a CT reaction of wanting to parent a mother whom she perceived was functioning like a child. This therapist may have been responding to the parent's need to be parented by becoming the parent herself.

Some therapists described feelings of sadness, compassion and empathy for families who were socially isolated or lacked connection to people and support. Solo parents were particular triggers for these emotional reactions, as they seemed to struggle with the demands of parenting and the requirements of therapy. This reaction was particularly prevalent for therapists who had their own experiences of having a solo parent themselves growing up. Although social isolation could result in shortcomings of care to children, this family situation did not appear to trigger negative CT for therapists such as anger and frustration in the way other situations did.

Being Friendly or Idealising the Therapist

Finally, some therapists in this study described positive feelings of warmth, joy and feeling special in relation to friendly children and families who made positive change and attributed this to the therapist. Positive CT reactions are reported in existing literature, including feelings of compassion, affection or identification with clients (Hay et al., 2019) and enthusiasm, happiness and warmth (Ulberg et al., 2013). Both in the current and existing

research, positive reactions occurred when therapists had a strong therapeutic relationship with their clients, when they felt connected to clients or when they were reminded of themselves or their own experiences. Positive subjective CT was triggered for therapists in this study when they were reminded of their own children. Positive CT could also lead to CT behaviour for therapists if they did not manage the emotion. For instance, some therapists spoke about how positive CT can lead to over-identifying with clients, which could then lead to behaviours such as making inappropriate assumptions, choosing irrelevant treatment pathways or holding inappropriate expectations for clients.

Therapists in this study also reported feeling uncomfortable in response to idealising clients, due to concerns that the idealisation could fluctuate to devaluation. Studies of adult CT have identified the idealisation and devaluation of therapists as a common CT trigger, often in response to clients with personality disorders (e.g. Gabbard, 1993; Tanzilli et al., 2017). These clients elicit feelings of helplessness, discomfort, anxiety and incompetence in therapists. However, this finding has not been replicated in the family therapy research.

Therapists' Conceptualisations of Countertransference

The development of the concept of CT has a long history. As discussed in Chapter One, there are a number of conceptualisations of CT across therapeutic perspectives. The results of this study reveal that the majority of therapists understood their reactions to be emotional, interpersonal, inevitable, and an important source of information. The following section will discuss these themes within psychodynamic, CBT and family therapy perspectives of CT.

Psychodynamic Conceptualisations

Many of the therapists in this study understood their CT to be a relational process arising from a combination of therapist and client factors. In this view, therapists saw CT to occur in the space between therapists and clients, rendering CT an interpersonal rather than intrapsychic process. This conceptualisation is consistent with psychodynamic views of CT, such as the relational view (Aron, 1990) and the integrative view (Gelso & Hayes, 2001) which view CT as a jointly created experience based on influences from both clients and therapists. The idea that CT reactions can come from both client and therapist contributions is a

commonly held view by the therapists in this study, as well as in existing CT literature (Gabbard, 2001; Gehlert et al., 2014). While therapists in the current study did not use the terms objective and subjective CT, their conceptualisations appear consistent with these terms. When CT was understood as a combination of client and therapist factors, therapists in this study spoke about the importance of having a good understanding of themselves so they could differentiate what they were bringing from what the client was bringing.

Related to this, many therapists in this study also spoke about their CT responses as a source of information about the client family system in some way. They appeared to share the view, initially proposed by Heimann (1950), that CT is a useful tool for understanding clients. They perceived CT as a source of information about their clients' internal worlds and interpersonal processes including early relationship experiences, the family dynamics and how other people perceive and respond to their clients. This appears to reflect the objective notion of CT, originally proposed by Winnicott (1949) and later related to family therapy by Gehlert et al. (2014).

Many therapists in this study also perceived CT as a source of information about their own internal worlds. This appears consistent with the subjective notion of CT (Gehlert et al., 2014; Winnicott, 1949). Some existing research suggests that therapists' subjective CT contribution comes from their unresolved history (e.g. Gehlert et al., 2014; Hayes & Gelso, 2001). In contrast, many therapists in the current study thought that their CT came from history that they were aware of and had addressed through their own personal therapy. Personal therapy supported therapists to be more aware of their CT reactions, and to manage and utilise these more effectively. This is consistent with the results of a study by Dubé and Normandin (1999) which found that personal therapy does not reduce affective responses in developing therapists, but rather it enables trainee therapists to be less reactive and develop a richer understanding of clients.

Cognitive-Behavioural Conceptualisations

Most therapists in this study conceptualised CT as primarily an emotional response to the client family, which can also include a rational or cognitive component. The majority of the therapists in this study completed their training in New Zealand or Australia, in which cognitive-behavioural therapy (CBT) is a prominent aspect of training programmes (Kazantzis

& Munro, 2011). As discussed in Chapter One, cognitive-behavioural therapists conceptualise CT as therapist emotions, emotional responses and emotional reactions of the therapist (Beck et al., 2004). Additionally, the role of cognitions and automatic thoughts are proposed by cognitive-behavioural therapists and researchers to be an important component of CT in CBT (Prasko et al., 2012). It is unsurprising therefore that therapists in the current study also predominantly conceptualised CT in this way. Some therapists did elaborate on this conceptualisation to include images, symbols, experiences, memories and states that occur in response to clients. Although broader in scope, these additions may provide more opportunities for therapists to recognise their CT. Moreover, consistent with Halerpin (1991), some therapists in the study agreed that the intensity of CT emotions is often greater than other feelings, which can be an indication that a CT reaction is occurring.

Family Therapy Conceptualisations

As mentioned in the introduction, there has been less discussion of the concept of CT in family therapy compared to CT in individual therapy. Traditionally, family therapists have examined issues related to CT, with concepts such as system suction, triangulation and split alliances. However, therapists in the current study did not use these terms when reflecting on their CT experiences. This may be a reflection on the teaching focus within clinical training programmes within Australia and New Zealand, in which CBT is a primary component (Kazantzis & Munro, 2011). Limited family therapy training and educational opportunities exist, as such the majority of family therapy practitioners have received their core training in other disciplines such psychology (Kumar et al., 2012). Additionally, teaching family therapy in-depth within clinical psychology training programmes is not a common practice with the majority of family therapy training taking place on the job (Habib, 2011; Kumar et al., 2009). As such, very few family therapy practitioners in Australia and New Zealand identify family therapy as their primary discipline (Arauz, 2002). This contrasts to overseas studies in which family therapy practitioners are family therapy trained, and identify this as their primary discipline and orientation (Booth & Cottone, 2000).

Despite participants not using family therapy concepts such as suction, triangulation, and split alliances, these processes were apparent and described in many of the CT experiences provided by the therapists in this study. This section examines family therapy

conceptualisations of processes that relate to CT using examples provided by therapists in the current study.

System Suction

Suction into the family system may be a process that occurred for some therapists working with families characterised by enabling or self-defeating patterns of behaviour. System suction refers to the process by which a therapist joins a family in a way that their behaviour becomes shaped by the family system (Minuchin & Montalvo, 1967). Some therapists in this study spoke of parents who were reluctant to change the family system or who enabled their children's unhelpful behaviour. These therapists described feelings of being stuck and hopeless with these families, which led to therapist concerns that they would contribute to the unhelpful pattern in the family. As such, these therapists were concerned that they had been or were being sucked into the 'stuckness' of the family, unable to create positive change. Additionally, system suction was also relevant for some therapists working with families with parental mental health difficulties. These therapists observed that children of parents with mental health challenges could become parentified, and look after their parents. System suction may have occurred when therapists were also drawn into looking after the parents' needs. This is evident in situations described by therapists in which parents used family therapy sessions to focus on their own individual needs, rather than those of their child or the relationship.

Triangulation

Triangulation may have occurred for some therapists working with abused or neglected children. Triangulation is the process by which a therapist enters into a relationship dyad within a family system (Bowen, 1976). This can become problematic if the therapist becomes caught up in the emotional process of the triangle without self-awareness. Therapists in this study who worked with children that had been abused reported strong CT desires to rescue and protect the children, a theme that has been found within research on child trauma and CT (e.g. Ingley-Cook, 2019, Shevade et al., 2011). The CT reaction, rescuing the child, was also one of five common reactions to child abuse proposed by Carr (1989). This

reaction becomes a process of triangulation when it is accompanied by anger directed towards a parent who abused the child or placed them in a vulnerable position, which some therapists in this study reported. As such, the triangle includes the victim (abused child), the perpetrator (the parent) and the rescuer (the therapist). This triangle is characterised by an intense emotional desire to protect the child and difficulty empathising with the parents, as described by some therapists in this study and by Carr (1989).

Split Alliances

Split alliances may have occurred for some therapists who worked with families who suffered a lack of support. Split alliances occur when therapists have a stronger alliance to some family members compared to other members in the family (Escudero et al., 2021). For instance, some therapists in this study reported feeling warm, empathic and compassionate towards solo parents, despite shortcomings in the way they cared for their children. These therapists often felt their affinity with solo parents was because of their own experiences of being raised by solo parents. Although not discussed by the therapists in this study, this could lead to the children feeling alienated or unheard or perpetuating an unhealthy family dynamic. Split alliances were also seen in therapists working with parents whom they perceived lacked insight into the child or family problem. Therapists found it difficult to encourage these parents to acknowledge their role in maintaining the problem through their own behaviour and reported feeling frustrated in response to this. A split alliance may have occurred for some therapists who tried to amplify the child's voice to increase parental awareness of their behaviour. As such, the therapist may have been more aligned with the child compared to the parents in this situation. It appears therefore that split alliances can result from both positive CT (empathy and compassion) and negative CT (frustration).

Towards a Unified Conceptualisation

The therapists in this study held strong interest in their reactions towards their clients and viewed the process of CT as normal and inevitable regardless of training or experience level. Although they thought, "everyone would agree that this stuff happens" (Participant 9),

therapists reported a number of barriers to being able to discuss CT with others. First, therapists in this study thought that colleagues and other professionals did not know how to talk about CT. The absence of a shared language for talking about CT had limited their ability and opportunity to discuss the topic in the workplace. Therapists who completed some or all of their training outside Australasia thought that the discussion of CT was particularly limited in New Zealand, which may be a result of the focus on CBT and other evidence-based practices such as dialectical behaviour therapy (DBT) and acceptance and commitment therapy (ACT) in training programmes. As CT is not commonly talked about within these frameworks, the opportunity to discuss CT is more limited. Second, many therapists described a stigma around the term CT, associated with shame, guilt and a sign of making a mistake in their clinical work. As such, therapists in this study reported having to feel quite brave to talk about CT with others, due to concerns about the potential risk to their professional image. These barriers may have been exacerbated by the lack of family therapy training in New Zealand and Australia. The neglect of family training has likely contributed to the absence of a shared language for talking about family therapy processes, including those related to CT, and the increased the stigma of this process.

The barriers discussed by the therapists in this study are consistent with many views held across the CT literature (Fauth, 2006; Kiesler, 2001; Najavits, 2000; Stratton et al., 1993). Although the term CT originates from psychoanalysis, some family therapists and researchers believe that the term CT has an important role in family therapy (e.g. Flaskas, 1989, 2005). However, some family therapists do not use the term CT, instead adopting other terminology that is thought to more accurately reflect the underlying principles and techniques of family therapy, as discussed in the introduction. There is an obvious need for a consistent term that describes the CT process in family therapy that could be used throughout literature and in practice, whether this is CT or another term. Without one theoretically consistent and accepted definition to describe CT in family therapy, family therapists may be limited in their ability to discuss this important process, support one another, normalise reactions and upskill in this area. Moreover, the exploration, consolidation and comparison of literature in this area is limited, which subsequently makes it difficult to identify areas to build on and enhance the collective knowledge relating to family therapy.

Therapists' Management of Countertransference

The therapists in this study spoke about a number of strategies they used to manage their CT reactions when working with children and families. Therapists reported that being aware of their responses to clients and reflecting on them was important for identifying, understanding and managing CT reactions. They also identified strategies they used before and within sessions to manage their CT. All of the therapists benefited from talking about their CT experiences in supervision, personal therapy or with colleagues.

Consistent with published observations (Friedlander et al., 2011), therapists in the current study believed that the management of CT is more challenging in family work compared to individual work, due to the number and complexity of relationships. Some therapists in this study thought that it was harder to utilise CT by naming reactions with families. This was due to concerns that by sharing a CT reaction that was perceived to reflect the feelings of one family member might lead to other family members feeling that the therapist is taking sides. This could lead to split alliances, possibly jeapordising the group alliance and treatment. However, most therapists in this study agree that there exists more collegial support when working with children and families, with greater room for co-working and discussing CT.

Awareness and Reflection

All of the therapists in the current study spoke of attempting to hold an awareness of their emotional reactions during therapy and creating space to reflect on them. Being aware of CT is viewed across CT literature as being a critical step in managing CT (Halperin, 1991; Hay et al., 2019; Hayes & Gelso, 2001; Mojta et al., 2014). Therapists in this study thought that this helped them to process the reaction, use the reaction as a source of information, and step out of CT enactment, consistent with existing research findings (e.g. Cartwright, 2011; Latts & Gelso, 1995; Robbins & Jolkovski, 1987). Sometimes the awareness and acknowledgement of an emotional reaction was enough for therapists to manage the emotion without needing to unpack the reaction further or seek additional support. In addition to being aware of emotional reactions, therapists spoke about holding an awareness of (a) their personal history, triggers and vulnerabilities; (b) repeating emotional reactions or behavioural patterns; (c) their role as a therapist, including the boundaries and limitations;

and (d) their self-state, such as how tired, fragile or stressed they felt on a particular day. Therapist self-awareness (awareness of thoughts, feelings, bodily reactions, imagery, urges and behaviours) and therapist personal insights (awareness of patterns of relating to others, sensitivities, needs, motivations and biases) were two important aspects of awareness proposed by Cartwright (2022) which aligns with the current study. This thesis study therefore both supports and adds evidence to the importance of awareness outlined in existing literature.

Pre-Session Management Strategies

Some therapists described strategies they used prior to sessions that helped them to manage their CT, including checking in with oneself, using mantras or writing down a session plan. They thought that these strategies helped them to be present with clients, hold onto the goals and values of the session, and/or manage the emotions of the session effectively. Research into the management of CT has primarily focused on how therapists can cope with CT reactions after they emerge, such as using professional or personal supports and self-care (Hay et al., 2019; Ingley-Cook, 2019; Shevade et al., 2011). However, this finding indicates that there are steps that therapists can take prior to experiencing CT to prepare them for emotional responses and possibly prevent their occurrence. More research into pre-session management strategies may provide clarity on the way in which this preparation assists with managing CT.

Within-Session Management Strategies

Within sessions, therapists in the present study described breathing, slowing down the session and making space for CT as ways of helping them manage their reactions. They reported that these strategies were useful grounding and emotion regulation techniques, particularly when they were responding physiologically to clients or feeling anxious. Breathing was suggested by Halperin (1991) to be useful for family therapists in disengaging from enmeshment, restoring boundaries and providing a moment of reflection as to why a therapist may be responding in a certain way. Moreover, breathing strategies may assist in maintaining the non-reactivity element of mindfulness, staying calm and present, which is associated with greater CT management (Fatter & Hayes, 2013) and to be particularly

important when working with children (Guest & Carlson, 2009). Therapists in this study slowed the session down using explicit and more subtle techniques, which they thought reduced the likelihood that they would automatically act on the response and was containing for clients. These results align with those of Cartwright et al. (2021) who found trainee therapists use strategies to calm, ground or slow themselves down in sessions to manage CT in individual therapy. The results of this study are also broadly consistent with studies on the management of CT in child and family therapy (e.g. Hay et al., 2019; Ingley-Cook, 2019; Shevade et al., 2011).

Utilising Countertransference

All therapists in this study spoke about the ways they used their reactions in their therapeutic work either by naming or by disclosing their CT to clients. Therapists did this in a number of different ways that varied in terms of their directness. Importantly, many therapists in this study reported needing to be certain that their reaction was not subjective before they spoke about it with clients. Therapists also mentioned that the utilisation of CT and the timing of this strategy was dependent on the client, the therapeutic relationship and the treatment goals. Cartwright (2022), based on her analysis of recent research, suggests that sharing CT reactions with individual clients can be helpful to clients as therapy progresses and clients become more aware of their own interpersonal processes. However, Cartwright (2022) advises that therapists should first process their CT and consider whether sharing CT is useful therapeutically, as well as whether the client is ready and able to receive this communication. The current study therefore supports the existing literature on the importance of utilising CT and the timing of this strategy, and explores how this relates to children and families. When it was therapeutically useful to do so, therapists in the current study thought that talking about their CT reactions with clients had positive outcomes. These outcomes included benefits for themselves (e.g. process and release the emotion), their clients (e.g. normalised and validated client emotions) and the therapeutic relationship (e.g. increasing closeness, facilitating important discussions and levelling the power imbalance).

The utilisation of CT has not been extensively researched in family therapy. Existing research on therapist self-disclosure tends to focus on therapists' disclosure of their own lives or experiences outside of therapy rather than their emotional reactions, and on disclosure

with individual adult clients (e.g. Hill et al., 2018). The meta-analysis conducted by Hill et al. (2018) reveals a range of positive effects resulting from therapist self-disclosure. These include enhanced therapeutic relationship, gains in client insight and improved client functioning. However, therapist self-disclosure also led to negative outcomes in up to a third of the cases in the studies reviewed, suggesting that therapists need to be cautious and strategic about the use of this strategy. This finding is consistent with the current study. Literature has also discussed the process of immediacy, or therapists discussing the therapeutic relationship with clients, such as disruptions or ruptures (Hill et al., 2018). Again, this strategy can lead to positive or adverse outcomes, depending on how it is used by therapists (Cartwright, 2022).

Some clinical writings discuss sharing CT responses with families, with diverse opinions. For example, Halperin (1991) advised family therapists to acknowledge CT behaviour to families when they have acted inappropriately on subjective CT. Whitaker et al. (1965) and Lantz (1993) argued that therapists should openly share all CT feelings with families, as this will make it less likely that they are acted upon and can facilitate growth and change in the family system. Finally, Ackerman (1959) thought therapists should be selective about which feelings they share with families. Further research into the utilisation of CT with clients and families would be useful to guide therapists in this area.

The Importance of Supervision, Personal Therapy and Colleagues

All of the therapists in this study reported that professional support from supervisors, peers, colleagues, and personal therapists was crucial in managing their CT reactions. The therapists reflected that talking to supervisors, personal therapists and colleagues helped them to feel contained, validated and process their CT. This is a strategy supported by a number of studies (e.g. Hay et al., 2019; Hayes et al., 2015; Ingley-Cook, 2019; Shevade et al., 2011) and clinical writings (Gehlert et al., 2014; Halperin, 1991; Shafranske & Falender, 2008). Additionally, these professional and personal supports were reported to help therapists understand the origin of the reaction, formulate client needs, inform therapy and increase empathy for clients. Consistent with Shafranske and Falender (2008), therapists did report that the supervisory working alliance and supervision style is critical in determining their comfort in discussing CT in supervision. Furthermore, due to increased fears of judgement

and feelings of incompetency as a newer therapist, many therapists in this study described being more reluctant to use supervision to manage CT early in their careers.

Therapists in this study additionally reflected that personal therapy helped them identify their own triggers, maintain reflective ability and reduce automatic reactions. This is consistent with the suggestion by Hayes (2004) that the greater resolution of therapists' personal issues or past conflicts puts the therapist in a better position to make use of their own experiences to manage CT and benefit the client. Indeed, the importance of personal therapy in managing CT and benefitting both therapists and clients is why personal therapy has been incorporated into psychotherapy training. Personal therapy is also proposed to be useful for cognitive-behavioural therapists in helping them develop an awareness of their underlying schemes and core beliefs (Haarhoff, 2006) and family therapists (Dubé and Normandin, 1999) in reducing reactivity to emotion.

Finally, in regard to interpersonal supports, the majority of therapists described speaking with colleagues as being helpful for assisting them in managing their CT reactions. The therapists in this study reflected that talking to colleagues helped the reaction to be processed immediately, often when supervisors and personal therapists were not available. Personal therapy also helped therapists identify if they were experiencing objective or subjective reactions, by understanding if other colleagues had experienced the same or different response. In particular, co-therapy was found to be useful by therapists, as co-workers can provide emotional safety and the space for therapists to regulate and settle themselves.

Perceived Impact of Countertransference

All therapists in the present study spoke about the impacts that they perceived CT had on the therapeutic process. Therapists spoke about the overwhelmingly positive effect that managing CT had for themselves, their clients and the therapeutic relationship. This is consistent with findings from existing research and meta-analyses that demonstrate that successfully managing CT reactions benefits the therapeutic relationship in individual therapy and leads to larger gains in therapy outcomes for clients (Hayes et al., 2011; Hayes et al., 2018). However, no family studies are included in these previous meta-analyses. The present

results suggest that the management of CT is equally important to the therapeutic relationship and outcomes in child and family therapy.

As mentioned in Chapter One, no research has been undertaken into the impact of CT on the working alliance in family therapy, the aspect of the therapeutic relationship that relates to the capacity to mutually agree and collaborate on the goals and tasks of therapy. This is despite previous research that shows CT can significantly impact the working alliance in individual therapy (Ligiéro & Gelso, 2002) and that the working alliance is crucial in determining treatment outcomes in individual and family therapy (Flückiger et al., 2018; Friedlander et al., 2018). The findings of this study suggest that CT plays an important role in the working alliance in family therapy. Therapists in this study described how managing CT (through being aware of CT, making use of interpersonal supports and using CT as a source of information) was helpful for guiding formulations, therapeutic work and the content of the sessions. By using CT to gain insight into clients, therapists may have more accurately conceptualised cases and planned treatment, perhaps leading to increased client engagement on the tasks of therapy. Indeed, some therapists reflected that managing CT led to increased client engagement and trust. Moreover, many therapists thought that utilising CT created closeness with clients and was a way for the therapist to join the relationship. This may have improved collaboration, as therapists and clients felt like more of a team.

The current study also adds to existing research by using a qualitative approach to examine family therapists' subjective experiences of managing CT for clients and themselves. All of the therapists agreed on the positive impact of managing CT for clients, including providing validation, normalisation, empowerment and role modelling. This aligns with the results of Mojta et al. (2014), which found that therapists' increased awareness of their own internal processes results in increased client's awareness of their own internal processes through role modelling. Client outcomes were not directly measured in the current study; however, therapists perceived improvements to client feelings and self-understanding, consistent with the findings of Gelso et al. (2002) in individual therapy. Furthermore, therapists in the current study described how managing CT was beneficial to themselves personally, in helping them retain empathy and be more compassionate towards their clients, themselves and co-workers. This enhanced empathy helped therapists withstand client emotions, depersonalise client reactions and maintain their boundaries. For some,

understanding their CT was enough for the reaction to dissipate, as suggested by Kohrman et al. (1971).

Conversely, and consistent with existing research on individual therapy (Gelso & Hayes, 2001; Hayes et al, 2018), unmanaged CT was perceived to have negative consequences by therapists in the current study. Therapists described instances of unmanaged CT, which included not being aware of their emotions, acting on their emotions during sessions or not being aware of the involvement of their personal histories. This often resulted in CT behaviours, such as ending sessions early, proceeding with therapy longer than they believed appropriate, being too assertive or restrictive during sessions, not calling clients back or sounding too angry or relieved when challenging clients called to cancel. For some therapists, unmanaged CT resulted in clients terminating therapy, consistent with the findings of Hill et al. (1996) and Shapiro (1974). Of note, therapists perceived unmanaged CT to adversely affect the working alliance, which once ruptured, was difficult to rebuild. This further supports the important role that CT has in relation to the working alliance in family therapy.

Clinical Implications

This study adds to the limited research in the area of CT when working with children and families and has a number of professional and training implications. All of the therapists in this study, irrespective of professional training or number of years' experience, described CT reactions in their child and family therapy work. However, many of them described the silence, resistance and/or shame associated with discussing these reactions with others. Existing literature on CT has referenced the concern that therapists may not accurately report on their CT due to fears of being judged (Najavits, 2000), and has supported the idea around the importance of normalising CT (Cartwright et al., 2015; Fauth, 2006). It appears that more work needs to be done in this area to increase the safety and confidence of therapists to discuss this important topic openly. This may be achieved with the inclusion of CT in training programmes, increasing the confidence and ability of supervisors to discuss CT and with access to post-qualification CT training. These resources could provide a common language, framework, vocabulary and systematic way for therapists to talk about and consider CT, and importantly to normalise CT for therapists.

The findings also point to the importance of therapists' awareness and management of CT reactions with children and families. There appear to be a number of strategies that therapists may find helpful in assisting them with their reactions. Creating space and time to reflect on reactions, particularly if they are repetitive or strong appears to be important for therapists. This could be done individually, with colleagues, supervisors or personal therapists. Within sessions, grounding and emotion regulation skills can help therapists manage their emotions in sessions and stay present with clients. Lastly, learning how to discuss CT with clients and how to assess the timing of this strategy is particularly important for therapists. Sharing CT reactions can be an effective strategy if therapists can consider the origin of the reaction, the readiness of the client and the strength of the therapeutic relationship. Moreover, it is important that therapists develop the skills for repairing relationships with families if therapists do not get the timing of this strategy correct.

Additionally, the findings discussed above highlight the need for psychology training programmes to prioritise the teaching of CT in order to prepare developing therapists to understand and manage their CT. This is important given most training programmes in New Zealand and Australia report following the scientist practitioner model of training, with a behavioural and cognitive orientation (Kazantzis & Munro, 2011). Indeed, therapists in the current study report limited CT specific training throughout their training programmes. Therefore, it seems important that clinical psychology training programmes include CT training in their syllabus, such as the types of experiences therapists might have, the potential triggers for these reactions and strategies for managing them. This could follow Hayes (1995) organisational framework for CT (origins, triggers, manifestations, effects and management), which has shown to provide trainees with a systematic method for reflecting on CT (Cartwright et al., 2021). Alternatively, Cartwright et al. (2016) developed and implemented a trans-theoretical training for developing therapists in programmes oriented towards CBT. Trainees reported that the training increased awareness, understanding and management of CT. Based on the findings of the current study and an important aspect of the training programme by Cartwright et al. (2016), it is important that training providers normalise and role model how to talk about CT by reporting on their own experiences.

This research also suggests the importance of CT training for organisations that work with children and families. Although there are multi-disciplinary teams of different professional trainings within these organisations, CT is likely to affect all staff members who

work with children and families, not only therapists. Therefore, CT training could aid them with understanding the impact that CT can have on themselves and their work and create a space in which staff can better support one another. This would create staff who are more able to speak openly about their CT, access more support that is informal and thus benefit themselves and their clients. Alternatively, peer supervision groups could serve a similar function for therapists in terms of accessing support, validation and assistance problem solving.

This study offers a number of suggestions for supervision. Supervision is one of the primary strategies therapists use to manage their CT, as reported both in the current study and by experienced supervisors (e.g., Gehlert et al., 2014; Shafranske & Falender, 2008). However, the effectiveness of addressing CT depends on the quality of the supervisor-supervisee relationship (Bucky et al., 2010). It seems important that supervisors lead by example by discussing CT in order to create a safe space, normalise reactions and role model how to have those conversations. Supervisors could use personal disclosure of their own CT to encourage openness. This is particularly important for new and developing therapists, who carry more feelings of incompetence. Finally, the study draws attention to the benefits of personal therapy for therapists. Developing therapists may wish, and should be supported, to seek their own personal therapy to increase their awareness and understanding of their emotional experiences, histories and how these may materialise in the clinical work. Ongoing personal therapy would be particularly beneficial for subjective reactions due to the professional boundary of supervision.

Limitations

There are a number of limitations to consider when interpreting the results of this study. First, while the number of participants is appropriate for qualitative research, the sample size was relatively small, focusing on the perspectives of 14 therapists. Second, therapists self-selected to take part in the research. These therapists may have a stronger interest and understanding of CT compared to others. Additionally, the lack of ethnic diversity of the participants is a limitation. The findings of this study may not be relevant for therapists from a range of cultural groups, such as Māori, Pasifika, or Asian peoples. It may be that

therapists from other cultures have different CT experiences or ways of understanding these. Hence, considering the above, it cannot be assumed the views and experiences of the therapists are representative of all therapists working with children and families in New Zealand or internationally.

There are also limitations of collecting data using interviews. While the use of interviews enabled the exploration of therapists' inner experiences, this method relies on the accurate reporting of therapists. The research was reliant on therapists sharing reactions that they felt comfortable disclosing and they may not have reported reactions or impacts that they felt uncomfortable with or saw as a risk to their professional image. Hence, their responses may have been affected by social desirability bias. Furthermore, therapists may not have accurately recalled the cognitive, emotional and behavioural responses they experienced in client sessions after they have occurred. These may have been influenced by the outcome of the session or events that occurred between the session and the interview.

Finally, due to the limitation of time, therapists shared a limited number of their overall CT experiences. Whilst the data collected was enough to address the research aims, the triggers and nature of CT reactions is unlikely to capture the full picture. There may exist additional triggering family behaviours and therapy situations, and additional reactions that therapists experience when working with children and families.

Future Research Directions

Given the findings and limitations of this study, there are a number of important areas for future research. First, more research is needed on CT, its management and impact on therapeutic relationships, working alliances and treatment outcomes in family therapy. The results from the current study do not clarify the actual effects of therapists' management of CT on client family outcomes. Future research methodologies, particularly quantitative methods that include measures of client outcomes could examine the link between particular CT management strategies and treatment outcomes. Much of the existing research on treatment outcomes uses proximal result, and so it would be beneficial for future research designs to explore longer-term effects of CT manifestations and management on family functioning. Additionally, the results of the current study have suggested the important role

of CT on the working alliance. Quantitative research that investigates the impact of CT on the working alliance in family therapy seems like an important next step, as it remains an important gap in the family therapy field.

Second, the majority of therapists in this study talked about utilising their CT reactions by naming or discussing them with clients if they perceived this as therapeutically useful. While the therapists in this study reported the benefits they perceived this strategy has for clients and therapeutic relationships, it is unclear how clients experience this process. Future research could examine how children, adolescents and families experience therapists' disclosures of emotional reactions during therapy. This would provide important insight into the impact of therapists' use of disclosure on the therapy relationship and treatment outcomes.

Lastly, there appears to be a gap in the New Zealand and international literature on how different cultures conceptualise and experience processes related to CT. As such, future research could seek to explore CT experiences of a more ethnically diverse sample size of therapists. Given New Zealand's bicultural status and its commitments to the Treaty of Waitangi, it is important that future research also explores how Māori populations conceptualise, understand and experience CT.

Conclusion

This qualitative thesis study examined 14 therapists' experiences and conceptualisations of CT when working with children and families, as well as the ways in which they managed these reactions. The study revealed five main types of family situations and behaviours that triggered CT reactions for therapists and the nature of these reactions. The study addresses an important gap in existing CT literature when working with children and families, which has historically relied on adult research, theoretical understandings and clinical writings. Therapists conceptualised their reactions as emotional, relational, normal, and an important source of information about the client family system. These conceptualisations were discussed within psychodynamic, CBT and family therapy frameworks. Therapists emphasised the importance of being aware of their reactions and reflecting on them in order to manage them effectively. Talking with others (colleagues,

supervisors and personal therapists) was described as incredibly helpful in assisting therapists in managing their CT. Finally, therapists spoke about utilising CT in the form of discussing reactions in sessions with clients and their perceived impacts of these management strategies on themselves, clients, the therapeutic relationship and therapy outcomes. These results have important implications for the training and supervision of developing therapists. Notably, developing a shared language and normalising the discussion of CT is important. Future research is needed into the relationship between CT management and treatment outcomes for families, including how families perceive the utilisation of CT.

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Appendix A: Advertisement

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

SCIENCE
SCHOOL OF PSYCHOLOGY

Science Centre
22 Symonds St, Auckland
T +64 9 373 7599
E psych.auckland.ac.nz
School of Psychology

Are you a psychologist or psychotherapist working with children and families?

My name is Imogen Nock and I am a Clinical Psychology Doctoral student at The University of Auckland.

As part of my research, I will be interviewing therapists about their experiences of countertransference (emotional responses) when working with children and their families.

The interviews will be either in group or individual format (whatever your preference!) and will take between 60 and 90 minutes. Interviews will be conducted in a location of your choice, and can also be completed via Skype.

I am seeking therapists working from any modality, who are currently working with or have worked with children and families within the last 18 months, and for a period of at least 2 years.

For more information, please contact Imogen Nock at inoc985@aucklanduni.ac.nz

A $30 voucher is offered as koha (token of appreciation) for those who participate.

This study is being conducted by Clinical Psychology Doctoral Student, Imogen Nock (inoc985@aucklanduni.ac.nz) and is supervised by Dr Claire Cartwright (c.cartwright@auckland.ac.nz) at The University of Auckland.

Approved by the University of Auckland Human Participants Ethics Committee on 04/11/2019 for three years, Reference Number 023531.

Appendix B: Participant Information Sheet

Building 721, Level 3
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School of Psychology
The University of Auckland
Tamaki Innovation Campus
Private Bag 92019
Auckland 1142
New Zealand

Title of project:
Therapist's experiences of countertransference when working with children and families.
Primary Investigator/Supervisor:
Dr Claire Cartwright
School of Psychology, University of Auckland
Student Researcher:
Imogen Nock, Clinical Psychology Doctoral Student
Researcher Introduction
My name is Imogen Nock and I am clinical psychology doctoral student. For this project, I am supervised by Dr Claire Cartwright at the School of Psychology, The University of Auckland.
Project description and Invitation
Countertransference is commonly understood as the therapist's emotional, cognitive and behavioural responses to the client and the way clients relate to them within therapy. This study aims to understand more about the countertransference experiences of therapists working with children and families. This study will explore the types of countertransference reactions of therapists working with children and families. This study will also attempt to ascertain how therapists from different treatment modalities both conceptualise and, subsequently, manage the countertransference reactions they have to this client group.
We believe it is important to understand more about countertransference as previous research has found that countertransference is a common reaction which can affect the therapeutic process including the working alliance and treatment outcomes. However, no past research has explored countertransference experiences of child and family therapists, and differences in countertransference reactions across a variety of therapeutic modalities. Moreover, how these reactions impact the therapeutic process within family work.
You have been sent this Information Sheet as you have shown interest in the study. If you are a therapist currently working with children and families or have done in the last 18 months, and for a duration of at least 2 years, we invite you to take part in this study. You can be working from any therapeutic modality. However, you are under no pressure to take part in this study, as all participation is voluntary. If you chose to take part, you will be compensated with a $30 voucher for your time.

Project Procedures

If you do decide to take part in this study you will have the option to complete an individual or small group interview of 3-4 members (preferred option selection on the consent form). This will take place in a location of your choice. Interviews will likely last between 60 and 90 minutes and 15-20 therapists will be interviewed. During the interview, you will be encouraged to talk about your experiences of working with children and their families and the ones that you have found most challenging. I am interested in your understanding of the experiences you may have had, how they may have affected the therapeutic process, and how you managed these experiences. If you discuss experiences working with clients, care will be taken to ensure that no client's names or identities are revealed. It is also a possibility that you may experience distress when speaking about your experience. If this happens, you may leave the group interview or stop the individual interview at any time you wish.

The interviews will be audio recorded and transcribed by a professional transcriber who will sign a confidentiality agreement.

Data storage/retention/destruction/future use

Your name will not be used on the audio-recording and your identity will be protected. Your participation in the study will also be confidential. Each recording will be assigned a number and the identity of the numbers will be stored in a separate location so that individual recordings cannot be identified.

If you do take part in the study, the recordings will be stored on a locked University of Auckland computer that is password protected. Transcripts will be stored in a locked cabinet at the University of Auckland by Imogen Nock. The data will be kept for ten years. All data will be destroyed when ten years have passed. The results from this study will be published in Imogen Nock's doctoral thesis (which will take three years to complete) and in a scientific journal. However, no individuals will be identifiable. If you take part in the study, you can request a summary of findings and this will be sent to the contact address that you provide on the consent form.

Right to Withdraw from Participation

If you participate in an individual interview, you may choose not to answer any particular questions, and you may stop the interview or ask for the audio-recorder to be turned off at any time, without needing to give a reason. You are able to withdraw your data, and are able to review the interview transcript for editing for up to one month after completing the interview.

If you participate in a group interview, you may choose not to answer any particular questions, or leave the interview at any time, without needing to give a reason. You are not able to be provided with a copy of the group interview transcript, or withdraw information already provided, as any changes could impact the contextual meaning of the remaining data. We ask that discussions from the group interview be kept confidential, and not discussed with anyone outside of the group, but we cannot guarantee all participants will comply with this request.

Contact Details

You may contact the researchers or Head of Department at any time if you require more information about the study.

Researcher	Supervisor	Head of Department
Imogen Nock School of Psychology University of Auckland **E:** inoc985@aucklanduni.ac.nz	Dr Claire Cartwright School of Psychology University of Auckland **E:** c.cartwright@auckland.ac.nz **Ph:** +64 9 923 6269	Dr Kerry Gibson School of Psychology University of Auckland **E:** kl.gibson@auckland.ac.nz **Ph:** +64 9 923 8556

For any concerns regarding ethical issues you may contact the Chair, the University of Auckland Human Participants Ethics Committee, at the University of Auckland Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz

Approved by the University of Auckland Human Participants Ethics Committee on 04/11/2019 for three years, Reference Number 023531.

Appendix C: Participant Consent Form

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The University of Auckland
Tamaki Innovation Campus
Private Bag 92019
Auckland 1142
New Zealand

CONSENT FORM

THIS FORM WILL BE HELD FOR TEN YEARS

Title of project:

Therapist's experiences of countertransference when working with children and families.

Principal Investigator/Supervisor:

Dr Claire Cartwright
School of Psychology
University of Auckland

Student Researcher:

Imogen Nock, Clinical Psychology Doctoral Student

I have read the Participant Information Sheet, have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have had them answered to my satisfaction. I agree to take part in this research.

- I understand that I am free to withdraw my participation at any time, and to withdraw any data traceable to me up to one month after the interview date.
- I agree for the interview to be recorded digitally, however, I can leave the interview at any time, without needing to provide a reason.
- I understand that a third party who has signed a confidentiality agreement will transcribe the audio-recordings.
- I understand that all of the data collected will be treated confidentially and that the researchers will undertake to keep the participants' identity confidential.
- I understand that all data will be stored in a secure location at The University of Auckland by Imogen Nock, under the supervision of Dr Claire Cartwright.
- I understand that all data provided by me will be kept for ten years, after which it will be destroyed.
- I understand that the results of this study will be published in Imogen Nock's doctoral thesis and in a scientific journal.
- I wish / do not wish to receive the summary of findings (If yes, please provide email address).
- I wish to take part in an individual / group interview (please circle preferred option)

Name: Email:

Signature: Date:

Approved by the University of Auckland Human Participants Ethics Committee on 04/11/2019 for three years, Reference Number 023531.

Appendix D: Interview Schedule

A Qualitative Investigation of Therapists' Experiences of Countertransference when Working Therapeutically with Children and Families.

INTERVIEW SCHEDULE

I am interested in hearing about your experiences of countertransference (emotional responses) when working with children and families. I do have some questions to guide that, but as we go please feel free to talk about other areas that I haven't asked you about. I will ask you about your general experiences of countertransference, and I will also ask you to think about some specific examples of therapy and clients, without giving names, to illustrate what you're saying and give us a clear picture of your experiences. Do you have any questions before we get going?

Demographics

- Gender
- Age
- What is your professional training?
- Where did you train?
- How many years post training experience?
- How many years spent working with children and families?
- Which therapeutic modality do you use when working with children and families?
- Have you had any specific training in countertransference?
- Have you had any training in managing countertransference?
- What is your understanding of countertransference?

Experiences of countertransference

Think back over your work and try to identify the different kinds of countertransference, or emotional reactions, you have experienced when working with children and families therapeutically.

- What family situations/dynamics do you find most personally challenging when working with children and families?
- What kind of reactions do these bring up for you?
- What was happening during therapy with this client/family that triggered this reaction? Was there any particular family dynamic or behaviours?
- What thoughts and feelings (about yourself, the client, and the situation) did you have?
- How did you make sense of the reaction at the time? What made you think that?
- Do you think your personal experiences impacted your reaction to this client?

Probes

- Can you think of another example where that reaction came up?
- Have you experienced any other reactions?
- What was triggering about that family?
- Have you experienced something similar to what they are describing? If not, how/why was it different?

Impact of countertransference

- Do you think your reactions have had any positive or negative impacts on the therapeutic process or therapeutic relationship? If so, how?
- Have you ever been impacted by the experience of countertransference? What impact has it had on you personally?
- Do you think countertransference is relevant to your work with your clients?
- How do you feel about working with this client group compared to working with adults?

Management of countertransference

- Can you think of times when you effectively managed a countertransference reaction? How did you manage it both during the session and afterwards? What supports did you have?
- Is there anything you would do differently?
- What have you learned about how to best manage countertransference?
- How do you look after yourself in this line of work?

Support and supervision

- What do you do for your own supervision? Does this involve talking about countertransference?
- Do you find your current method of support to be successful?

Appendix E: Confidentiality for Transcribers

Building 721, Level 3
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New Zealand

CONFIDENTIAL RESEARCH MATERIALS
STATEMENT OF CONFIDENTIALITY
For Researchers and Transcribers

Title of project:
Therapist's experiences of countertransference when working with children and families.

Researcher:
Imogen Nock, Clinical Psychology Doctoral Student

Supervisors:
Primary: Dr Claire Cartwright
Secondary: Dr Kerry Gibson
School of Psychology
University of Auckland

I _____ agree to transcribe the audio-recordings for the above research project. I understand that the information contained within the audio-recordings is confidential and must not be disclosed to anyone other than the researcher and the supervisor. I acknowledge the risk of exposing sensitive information about the research participants and therefore I will not discuss the participants or the details of these interviews with anyone other than the researcher and the supervisor. If I recognise a person's voice or identity I agree to immediately stop transcribing and contact Imogen Nock. I understand that all of the data will be removed from all electronic devices upon satisfactory completion of this thesis. I shall delete any copies that I may have made as part of the transcription process.

Signed: Date: