

Challenging Emotions in Psychotherapy: Case Studies

It is impossible to take a cookbook approach to understanding transference and countertransference. Each psychotherapist–client dyad is affected by the unique personal histories of both participants. Nonetheless, this document will provide a few examples of common transference and countertransference situations in psychotherapy so that you can see how the psychotherapist might interpret and use these feelings in the therapy. For some of these situations, I make a few comments on the therapeutic management of the situation. For other situations, I supply the vignette and some information and leave the management of the therapy for class discussion.

Note that all cases are composite or invented. None of these are based on any single client. A few cases are cited from another source.

THE FEARFUL, DISTRUSTING CLIENT

Kathleen Gibson sees a new client for an intake session. She is frustrated that the client will not reveal anything about his history. “You have to trust me,” she insists. The client then describes a history of repeated sexual trauma from age 5 to age 15. He cries uncontrollably at times and hyperventilates. At the end of the session, Kathleen gives him an appointment for a follow-up appointment, but he never comes back.

Elena Hernandez is a 27-year-old single woman who has come in for psychotherapy. She is being seen by Patrick Kelly, a mental health trainee. Patrick is trying to get a social history and an understanding of any symptoms she might be having. She works for a travel agency but feels that her boss treats her with contempt. She is single and has a 3-year-old daughter. She appears to be estranged from most of her family. She has one friend who lives in the same apartment building as she does, but her attitude is a bit negative toward the friend since the friend is on disability for mental illness. She doesn’t go to church and doesn’t appear to have any other friends. In response to his questions about symptoms, Elena’s responses are vague and evasive. At times, she appears suspicious of his motives. She denies having any experiences of sexual trauma but does so in a manner that makes Patrick wonder if she is being honest. Patrick hypothesizes that Elena’s distrust and avoidance of closeness developed for a good reason—the reason might have been childhood abuse

or other maltreatment. He sees that she is not ready to talk to him about anything that leaves her feeling too vulnerable. He says, "I see that you have been a little vague when I asked you questions. Perhaps you are uncertain about whether you are ready to trust me with personal information. Is this right? [Elena nods her agreement] I'm sure you have a good reason for that. Can you tell me what your concerns are?" Elena starts to talk tentatively about her fear that Patrick will hurt her if he knows too much about her. At the end of the session, Patrick assures her that he will not press her for information that she is not comfortable telling him. Near the end of the session, he assesses risk issues: "Before we stop today, I would like to ask you just a few questions that have to do with your safety. Can you see if you can try to answer them for me?" Elena is cooperative with brief assessments of suicide and violence risk. When Patrick talks with his supervisor later, he talks about his understanding that Elena needs to develop a trusting relationship with him and that this will not happen quickly. He and his supervisor agree that it may be weeks before he knows much more about her history but that establishing a strong therapeutic alliance and keeping Elena in therapy is more important.

Distrust can be a confusing and distressing reaction from a new client who does not even know you well. Clearly, Elena's distrust of Patrick in the second of the previous vignettes is a transference reaction. Addressing her distrust is an important first stage in therapy. These two vignettes illustrate effective (Patrick) and ineffective (Kathleen) ways to address distrust. Patrick understands that his client has developed her suspiciousness and distrust for a good reason. She has almost certainly been or felt mistreated by someone important to her. For example, Berenson and Andersen (2006) found that female undergraduates with a history of physical or emotional abuse had a predisposition to transference feelings of mistrust, expecting rejection, emotional indifference, and desire to avoid closeness. These feelings must be an early focus of therapy. See Courtois and Ford (2013) for further advice about distrust in psychotherapy; also consult with a supervisor who is knowledgeable about psychotherapy with trauma survivors.

THE NEEDY CLIENT AND THE PARENTAL/PROTECTIVE- FEELING PSYCHOTHERAPIST

Jamie Gutierrez is mental health trainee working in a large medical center. He is assigned a new client who is in the partial hospitalization program. The client is a 35-year-old woman who has post-traumatic stress disorder (PTSD), borderline personality traits, and recurrent major depression. The client talks to him about her problems, including her concerns about her psychotherapist, who she has seen weekly for 2 months. The client describes her psychotherapist as harsh, cold, and demanding. She says that she has difficulty attending her therapy sessions. Jamie sympathizes with her and suggests that the client work with him in long-term psychotherapy instead.

He tells her to call the psychotherapist and cancel her future appointments. Later, talking to his supervisor, he discovers that the previous psychotherapist is the medical center's foremost expert in treating borderline personality disorder. The supervisor advises him that, additionally, this psychotherapist is known to be warm and helpful to clients and staff. With the supervisor's help, Jamie realizes that he has taken the client's transference as reality and that he has some personal countertransference issues around rescuing people who are helpless. He realizes that soon the client will see him as harsh, cold, and demanding as well and describe him in this way to other staff.

Jeff Chung is a mental health trainee at a medical center. He has a client with PTSD who tells him that she can't trust him. He wants to help her, so he goes above and beyond with his efforts to place her in appropriate housing, get benefits, and so on. In fact, the client doesn't lift a finger; Jeff does all the work for her. He hopes that this will show her that he is on her side and can be trusted.

Being overly gratifying in response to the client's transference issues is a common therapeutic mistake according to research by Gelso, Hill, Mohr, Rochlen, and Zack (1999). Here, Jamie has risked alienating other mental health staff by going out of his way to protect a client, not understanding that her reaction to the original psychotherapist was based in transference. Just because the client feels needy and helpless, this does not mean that Jamie must be protective in return. This vignette also illustrates a common clinical phenomenon in mental health agencies called *splitting*. Here, the client has (unconsciously) split her psychotherapists into two opposing camps since they have not been in good communication about her care, and thus one of them mistook the client's transference for reality.

The second vignette is another example of being overly gratifying to the client; Jeff is taking far too many steps to help her rather than addressing her transference reaction of distrust and neediness as a therapeutic issue. Getting overinvolved with the client is a one form of problematic countertransference behavior (Hayes & Gelso, 2001). Here are some other examples of being overinvolved:

- Trying to rescue a client while ignoring the client's need to develop own coping skills
- Pushing confrontation of an abuse perpetrator or urging legal action against an abuse perpetrator without regard to the client's wishes or to the likely ineffectiveness of these actions to satisfy the client's emotional needs
- Insisting on the client becoming total estranged from an abusive family

THE BORING CLIENT AND THE DISENGAGED PSYCHOTHERAPIST

Miriam Weinstein has a client who keeps talking about the same marital problems over and over. He is boring her with this repetition. She is frustrated

that he is not following through on getting marital counseling, which is obviously needed. Miriam says to the client, "I'm realizing that we've talked about this issue on a number of occasions before. Somehow it must be helping you to go over this again, or perhaps you may want to get something out of our discussion that you haven't gotten yet. What do you think? Can you give me some feedback about this?" The client's response indicates that he has been ruminating incessantly about these issues between sessions, trying to figure out a way to address them, but not coming up with any new insights. Miriam then asks, "I'm noticing that you continue to be upset about these marital problems but that something is holding you back from calling to make an appointment for marital therapy. Do you have any idea what that is?"

Being bored by a client is something that happens occasionally to every psychotherapist. However, psychotherapists often feel guilty about being bored and blame themselves for not attending more closely. Or they get frustrated with the client and insist on behavior change that the client does not pursue. Actually, if you are bored by a client, this is important information about the treatment that you need to consider carefully. There are many reasons why a client might be boring you and many possible interventions for addressing this.

When the client feels boring, often the client is verbally ruminating about subjects that he tends to ruminate about when alone. *Rumination* is a type of thinking that is common in people who worry, and who have anxiety or depression; the client is thinking about the same concerns over and over again, circularly in the same way.

Perhaps your countertransference response of boredom is telling you something about the client. When you think this may be the case, Yalom (2002) suggests the following intervention:

"For the last several minutes, I notice that I've been feeling disconnected from you, somewhat distanced. I'm not sure why, but I know I'm feeling different now than at the beginning of the session, when you were describing your feelings... or last session, when you spoke from the heart." (Yalom, 2002, p. 66)

Note that the word "boring" appears nowhere in this intervention. Yalom doesn't hypothesize why the client is boring him, but he offers his reaction to the client as a genuine observation of her behavior and encourages further exploration. Brown (2001) tells about a course of psychotherapy in which she was bored by a client who she actually liked very much. She hypothesized that the client had some way of interacting with others that deflected attention from herself. When Brown shared these observations with the client, the client was able to be in touch with her ambivalence about closeness. One final consideration is that you may be bored because the client is talking about ruminations and, in essence, is ruminating verbally. In that case, you may need to discuss and target the symptom of rumination therapeutically.

Alternatively, your countertransference response of boredom could be telling you something about yourself. Pope, Sonne, and Greene (2006) suggest that boredom might be "a clue that the psychotherapist is on some level fighting

against awareness of taboo topics or acutely uncomfortable feelings or impulses” (p. 82). Perhaps in the vignette, Miriam may be avoiding talking about the client’s problems with sexual functioning, his history of sexual abuse and how that affects his marriage, or other possible uncomfortable topics. Similarly, Hayes and Gelso (2001) suggest that being bored in a therapy session might mean that you are distancing yourself from the client because some of your unresolved personal issues are being stimulated by what the client is talking about. This might be the case if Miriam, herself, were having marital problems but did not want to think about them.

THE BORDERLINE CLIENT AND THE IRRITATED/FRUSTRATED PSYCHOTHERAPIST

Belinda Brown is a 42-year-old psychotherapy client recently assigned to Cliff Yakamura, a mental health trainee. Cliff sees her in a community mental health clinic. Belinda has been treated by various students for a year each, and in his review of Belinda’s chart, Cliff sees that each student made a diagnosis of borderline personality disorder. Cliff calls her to schedule her first appointment. Belinda makes sarcastic comments to him over the phone and calls him “another little newbie” and “fresh meat.” During her first session, she talks about how fantastic her previous student psychotherapist is and how she is sure that Cliff will never be able to live up to that standard. She insists that he print out his progress notes for her to review on a weekly basis, grumbling vaguely that “errors have been made in the past.” Cliff responds, “I’m sorry, but I don’t have the time to print out your progress notes for your review on a weekly basis, and, frankly, I don’t think it would be the most effective use of your therapy hour. I understand that you have a right to see the notes, but we will need to work out something else. Before we discuss that, could you tell me how you feel that it would help you to see these notes?” Belinda changes the subject, then insists that Cliff give her his personal cell phone number because “all of my other student psychotherapists did.” Cliff states, “I’m sorry, but I have a strict policy not to give out my cell phone number to clients. There is a 24-hour hotline available to you in an emergency and you can leave a message for me on my voice mail at the clinic anytime. But I am curious, how do you feel it would have helped you to have my cell phone number?” Belinda tells him that he’s too rigid, and then she spends the rest of the session complaining about how her family has been treating her lately. It is time to schedule the next appointment. Even though she is on disability and has few scheduled activities, Belinda wants an appointment in the last hour of the day since she says that is most convenient for her. Cliff does not want to see her then, as he would prefer to spend that time to do his progress notes and consult with his supervisor about any emergent issues. He firmly states, “I’m sorry, but I’m not available to see you at the last hour that the clinic is open. Here are the times when I could see you: 2:00 P.M. Monday or 3:00 P.M. Thursday. Which would you prefer?”

We can imagine that Cliff might feel angry and frustrated with Belinda. Coping with the angry/entitled client is challenging because of the intense emotions provoked. In a study using vignettes of three different clients, Brody and Farber (1996) found that psychotherapists indicated that they would feel especially angry and irritable when working with a borderline client and that this client would be especially difficult to like and to feel nurturing and compassionate toward.

Two common reactions are to behave angrily in return or to try to mollify the client and accede to demands, hoping that the client will calm down, feel nurtured, and like you. Neither of these approaches is effective. Behaving in an angry manner will result in a therapeutic impasse. Mollifying the client will just lead to increased demands and further violation of therapeutic boundaries. Do your best to react to the client in an appropriate professional manner instead.

However, there will be moments when your irritation with the client is obvious. Gabbard (2001) suggests the following intervention in this situation:

“I feel like we’ve entered familiar territory here. You seem to resent my efforts and make accusations against me. I get irritated and defensive and make things worse. Then we reach a stalemate where I feel frustrated and impotent and you feel you’re not getting any help. How do you understand this pattern, and what do you think we can do about it? (Gabbard, 2001, p. 987).

He is making a transference interpretation and simultaneously encouraging the client to think about more adaptive ways of relating. Even a highly experienced psychotherapist such as Gabbard will sometimes find himself reenacting relationship patterns with clients; he shows in this quote how to address that therapeutically.

Like Cliff, you must patiently and firmly set appropriate limits and provide the client with an opportunity to discuss emotional reactions to this limit setting. Do not make extra allowances for the client, such as offering an appointment time that does not work for you; the client will not appreciate your extra effort and instead will demand even more. The client’s dependency needs cannot and should not be fulfilled by you, the psychotherapist. If you accede to too many demands, you will feel increasingly resentful and abused, decreasing your ability to be therapeutic. Kernberg, Selzer, Koenigsberg, Carr, and Appelbaum (1989) provide timeless advice on managing difficulty transference and countertransference situations with borderline clients.

THE PSYCHOTIC CLIENT AND THE HELPLESS/INADEQUATE- FEELING PSYCHOTHERAPIST

Yuri Petrovich is in treatment for schizophrenia. He was recently discharged from the hospital and is assigned to Andrea Mason, a mental health trainee. Yuri says that he wants to get a job and that he is lonely and wants a girlfriend. Andrea worries that he is too mentally ill to maintain a job and

wonders about how he would find and maintain a healthy relationship with a girlfriend. Yuri tells Andrea that he hears his neighbors talking about him through the wall. He says that the neighbors are commenting on his movements and criticizing him with foul language. He is thinking about telling them off. Andrea feels anxiety that Yuri might get into trouble by acting on these symptoms and suggests that he shouldn't. Yuri accuses Andrea of not believing him. Clearly, Yuri doesn't have any insight that he is having hallucinations. Andrea makes the following intervention: "Yuri, I understand that you are hearing the voices of the neighbors, and it sounds like that is very distressing for you. I'd like to tell you my perspective on this, and I hope you'll hear me out. We might have a disagreement on this, but if we do, I hope that we can agree to disagree. I don't doubt at all that you are actually hearing voices. However, I think that what you are experiencing is what's called a hallucination. A hallucination is a sensory experience that your brain generates within itself. So, if you're hearing a voice, your brain is generating a voice in the same exact area that it processes voices that you hear through your ears. So these voices, even though they are generated in the brain, seem just as real as actual voices you hear. Do you have any questions about this? Now I understand that this is a lot to take in, and you might not be sure that I am right. That's okay. Can we agree to keep discussing this issue as we go along? I'd like to suggest that we both try to keep an open mind about this. If you find that the voices decrease when you take your medicine, I'd like you to consider that they might be hallucinations, okay?"

Horowitz (2002) eloquently described the emotional devastation of schizophrenia:

"Trying to comprehend the magnitude of loss that they endure is beyond imagination. Life prospects change forever. Social circles contract; vocational choices narrow if not vanish; once celebrated accomplishments fade into the past. The onset of illness deals not only a harsh blow to self-esteem but to the very core of identity. The grief that attends a wound to the self differs markedly from grief that accompanies the loss of a loved one. With the former, the object of loss—the self—is ever present, an eternal reminder of what once was. Remnants of the past linger like a haunting legacy that awakens remembrances of an unlived life. Even though pain may ebb for extended periods, there is always the risk that the wound to the self is reopened again whenever the limitations imposed by the illness hamper the realization of some long-cherished goal and the disappointment of unmet expectations surges anew." (Horowitz, 2002, pp. 236–237)

Clearly, no empathetic psychotherapist can remain untouched by this. In a study using vignettes of three different clients, Brody and Farber (1996) found that psychotherapists indicated that they would feel especially anxious and hopeless when working with a schizophrenic client and that this client would be especially challenging.

Early in treatment, clients with psychotic disorders may still be having prominent positive symptoms—hallucinations, delusions, and thought disorder. The clients often have enough insight to realize that the therapist doesn't believe in the hallucinations and delusions but not enough insight to realize that these are symptoms. The client's friends and relatives may have been telling him that these things aren't really happening, but he knows what his experience is. The severity of the client's illness can make both him (Nordentoft et al., 2002) and you feel hopeless, and depression is indeed an important comorbid concern with schizophrenic clients (Dixon et al., 2001).

It is normal to feel uncomfortable and hopeless about psychotic symptoms at first. Most psychotherapists do. However, these clients can be very fulfilling to the knowledgeable psychotherapist; they can make great improvements, and their potential has historically been grossly underestimated and undertreated. If your clients have psychotic disorders, attempt to educate yourself and the rest of the staff about effective interventions for improving their functioning and quality of life, including medication management, psychoeducation, living skills training (for information on all three of these, see Falloon, Held, Roncome, Coverdale, & Laidlaw, 1998), cognitive therapy (Butler, Chapman, Forman, & Beck, 2006), social skills training (Bellack, Mueser, Gingerich, & Agresta, 1997), family group psychoeducation (Hogarty et al., 1986), cognitive training (Twamley, Jeste, & Bellack, 2003), and vocational rehabilitation (Twamley, Jeste, & Lehman, 2003). This knowledge will increase your comfort level and hopefulness with this population.

Clients with psychotic disorders often are paranoid and suspicious. These feelings are related to their paranoid delusions, but you may have countertransference responses to them nonetheless. One response would be to placate the individual in order to build rapport, such as by agreeing that the neighbors are indeed talking to him. However, you don't really believe this, so it would be a therapeutic error that might lead to inappropriate client behavior. Another response would be to be evasive; however, this will just reinforce the client's paranoia. Remember that ample research supports the value of psychoeducation in schizophrenia (Lukens & McFarlane, 2004). It is helpful to take a nonconfrontative psychoeducational approach, as Andrea does.

SEXUAL FEELINGS AND BEHAVIOR IN THE CLIENT

Harry Gray is a 32-year-old psychotherapy client assigned to Melissa Paul, a mental health trainee. He often comments on Melissa's outfits, initially telling her that she looks "lovely," but in the most recent session, he said that she looks "hot." Melissa has the uncomfortable feeling that he is looking at her breasts at times during the therapy session. He has remarked that he wishes he had met her socially instead and states that he feels that they could have been "very close special friends," emphasizing his point with a wink.

Kim Fisher, a mental health trainee, is talking with a new client in her office. The client is low functioning and has severe mental illness. As the session progresses, she notices that the client is wearing loose shorts, that his penis is poking out of one of the legs of the shorts, and that he is rubbing his penis through the cloth. Kim tells the client that she sees him touching himself and that the session will have to end for today. The client protests that he wasn't doing anything, but she insists that the session is over anyway. She then finds her supervisor and talks the situation over. They explore whether Kim should keep the client or whether the client should be transferred to a male psychotherapist.

A survey of psychologists found that almost three-fourths had been told by a client that the client was sexually attracted to the therapist, and nearly 90 percent felt that a client had flirted with them (Pope & Tabachnick, 1993). In addition, the survey found that nearly one-fifth of the psychologists had experienced a client touching his or her genitals during a session, as in the second of the previous vignettes.

In response to a client's sexual feelings or behavior toward you, you might feel anxiety, embarrassment, or anger (Hillman & Stricker, 2001), or you might have other feelings, including sexual ones, in return. One suggestion for managing a client's sexual transference is this: "[The student] therapist reinforced that although it was her responsibility to ensure that their sessions would always remain safe and professional, talking about and discussing these feelings could be important in helping him understand how he relates to [others].... She added that feelings and behavior are two very different things" (Hillman & Stricker, 2001, p. 275). They note, additionally, that as the transference was explored verbally, the strength of the sexualized feelings lessened.

SEXUAL FEELINGS IN THE PSYCHOTHERAPIST

Deepa Nair, a mental health trainee, has ambivalent feelings about her client, Ellen Hansen. Ellen is a lesbian and has been talking about her relationship problems with her partner, Patrice. Occasionally, she will talk about their sex life, which Deepa finds unexpectedly titillating. Deepa has always thought of herself as heterosexual, which increases her feelings of sexual confusion about the client.

[The intern psychotherapist, Martin] noticed that he was sexually attracted to his client in about the second session, when he experienced an emotional and physical response to her presence. The client was not only physically attractive to Martin but also impressed him as articulate, sophisticated, and generally richer in interpersonal attributes than other clients. Martin had never been sexually attracted to a client before and was very distressed by the situation; he experienced a range of negative feelings. For example, he felt embarrassed that he was sexually attracted to someone who had numerous complex problems. He felt guilty that he was devoting more attention to this client than to others, and he felt "tortured" inside because he enjoyed being

attracted to her and did not try to change his feelings. In fact, as the sessions progressed, Martin found himself looking forward to seeing the client each week. Thus, the sexual attraction created an emotional dilemma that he struggled to manage. (case example from Ladany et al., 1997, p. 420)

A psychotherapist often feels ashamed of being sexually attracted to a client even when the psychotherapist is not at risk of having sex with the client. Research has shown that most psychotherapists have occasional sexual attractions to clients (Bernson, Tabachnick, & Pope, 1994; Pope, Sonne, & Greene, 2006). However, there is profound ambivalence and shame about this as well; most psychotherapists also believed that simply feeling sexually attracted by a client is unethical (Pope, Tabachnick, & Keith-Spiegel, 1987), probably because, as we all know, sex with a client is always inappropriate. In a qualitative study with psychology interns, Ladany et al. (1997) found that sexual feelings on the part of the therapist led to being more invested in and attentive to the client but also (understandably) to feeling distracted. The student psychotherapists also struggled with boundaries with these clients, some by distancing themselves, while others struggled with being overly giving and protective.

It may help to consider the types of countertransference we talked about in the text (Willer, 2013). Here are some possibilities (the first two are adapted from Pope & Tabachnick, 1993). Perhaps the client is projecting a particularly sexy image, wearing short skirts, high heels, low-cut blouses, and so on. Or perhaps he or she is being flirtatious. In this case, your reaction reflects a common reaction among others who encounter the client. Perhaps the client just happens to be your “type,” and your sexual interest is the normal response you would have had if you met the client under other circumstances. Perhaps the client was abused as a child and thinks that her sexuality is the only thing that others value about her. Perhaps the client gets his sexual and other close feelings confused. Coping with these feelings is a delicate and complex issue. Experts agree that telling the client about the psychotherapist’s sexual feelings is rarely therapeutic (Gutheil & Gabbard, 1998; Jorstad, 2002). When this comes up for you, consider discussing the feelings with peers, supervisors, or your own psychotherapist. And if you have any concerns that you might act on them, you are ethically obligated to seek assistance, such as consultation and psychotherapy.

THE LIKED CLIENT AND THE CHALLENGED PSYCHOTHERAPIST

[I am challenged by] those clients about whom I think, “I wish I had met you outside of therapy.” These are people who could be my friends, I think, if only I had not been their psychotherapist. In one such instance, with a woman I’ll call Joyce, I responded to those emotions by becoming extremely distant and formal with her as a somewhat conscious strategy to insure that nothing resembling a friendly interaction would happen in the course of the therapy.

I became the boundaries queen, keeping every single rule of therapist disengagement that I could think of. I usually self-disclose; I shut that down. I normally respond straightforwardly to client questions about my inner state; I became the master of deflected “and what do you think I’m feeling?” Of course, since I was quite right that Joyce would have made a lovely friend for me if I’d met her under different circumstances, she was intuitive and emotionally attuned, and knew that there was something very wrong. She expressed her genuine affection and concern for me, which I responded to by becoming even more formal and distant. This, in turn, wounded her in some very core places, where she had been punished and rejected for her ability to see just how few clothes the emperors in her family were wearing. The process went on for nearly a year, during which therapy became less and less productive for her. The boundaries were impeccable, but that’s about all. She finally became angry enough with me to let me know clearly what she was experiencing. And I was finally able to see how my attempts to avoid my grief and feelings of loss about never being able to have this woman as my friend, as well as my fears of losing control and pursuing a friendship if I allowed myself to experience the warmth and care I had for her, were translating into distance, indifference, and lack of engagement. Having been able to get more honest with myself about what was going on, I began the slow and difficult process of mending the relationship, which included my acknowledging that she was special to me in this way even though I knew that a friendship would never occur. (case example from Brown, 2001, p. 1011)

I realized that two things sparked my extreme countertransference with Elly. First, I liked her too much—for her personal beauty and competence, and for her taking so readily to my theory and practice of REBT. You could say I liked her for herself and for appreciating me and my therapeutic theory. Second, I was afraid to uncomfortably confront Elly about her LFT [low frustration tolerance—in this case with boyfriend’s] problems. I was afraid, I realized, that I would have a difficult time convincing her and thought that I might lose her as a client. I would never put myself down if this happened, but I might consider it too uncomfortable and too interruptive of the pleasure I had while seeing Elly. So, my LFT produced countertransference reactions in me that interfered with my helping Elly. Bad! It didn’t make me a rotten therapist but did make me ineffective with Elly. I apologized to her for my mistake and went back to cultivating my garden. I learned my lesson and rarely made the same countertransference mistake again. (case example from A. Ellis, 2001, p. 1003)

Two expert psychotherapists shared the previous vignettes. Both of these discuss some of the inherent pitfalls of working with the liked client. Brown talks about keeping too much distance for fear that if she didn’t, she would have gotten too close. Ellis discusses placating the client to maintain the comfort and ease of the therapy.

THE ANXIOUS/DEPRESSED CLIENT AND THE CONCERNED PSYCHOTHERAPIST

Akbar Khan is a 19-year-old Pakistani American psychotherapy client recently assigned to Aiyana Reed, a mental health trainee. Aiyana sees Akbar in a student health clinic at a large state university. Akbar is an engineering major, and he has a few close friends from high school. He has not made any new friends at college and spends much of his time in his dorm room studying or playing video games. As she gets to know him, Aiyana notes that Akbar tends to answer her in monosyllables whenever possible. He demonstrates little spontaneity in what he reports to her and seems anxious and on edge. He readily admits that he is fearful of meeting others and believes that they will judge him negatively. Some fellow students have made insensitive comments and jokes to him as well about his ethnic background, reinforcing his fears.

In a study using vignettes of three different clients, Brody and Farber (1996) found that psychotherapists indicated that they would feel more depressed working with a depressed client but that this client would be especially likely to be gratifying to work with and to help. The depressed client was seen as most likable, and the therapists easily felt nurturing and compassionate toward the depressed client. However, the client in this vignette is anxious about interacting with others and may have a social phobia in addition to being depressed. He also struggles with experiences of racial discrimination that have contributed to his social avoidance and fears.

THE DISLIKED CLIENT AND THE OVERWHELMED PSYCHOTHERAPIST

Guillermo Moreno is a mental health trainee working in an intake clinic. A client comes in for an intake and during the course of the interview reveals that he was incarcerated for sexually abusing his stepdaughter. The client was recently released into the community. Understandably, Guillermo finds this behavior repulsive and is disgusted with the client. He finds this behavior so creepy that he just wants the client to leave as soon as possible rather than finishing assessing him thoroughly and making an appropriate treatment plan.

Elizabeth Little is a mental health trainee working with Trisha Yates, a client who has PTSD and abuses alcohol periodically. Trisha leads a disorganized and chaotic life. She has physically abused her children in the past and is being monitored by the state. She has been hospitalized many times for suicidal behavior. Elizabeth notices that she has a feeling of dread every day she

is scheduled to see Trisha. She finds the negative way that Trisha talks about her children to be abhorrent. She finds herself having fantasies that Trisha will drop out of treatment so that Elizabeth will no longer have any responsibility toward her. She finds that she tends to eat junk food for lunch when Trisha is coming in the afternoon.

Both of the clients in these vignettes are very difficult to like. Yet, clearly, both need help and are asking for help by coming to therapy. Sooner or later, we will all be confronted with disliked clients. Coping with them is a difficult task in managing countertransference. Discussions about these feelings with supervisors, colleagues and consultants is the most helpful way to address them.

THE NARCISSISTIC CLIENT AND THE DISTANCING PSYCHOTHERAPIST

Anna Saunders is a mental health trainee who is doing supportive psychotherapy as an adjunctive treatment for pain patients. She is assigned a new patient who is a successful business executive. He had an injury and is now left with chronic pain. The patient spends much of the session bragging about his financial success, his forthcoming management book (although he has been looking unsuccessfully for a publisher for over a year), and his anticipated substantial speaking engagement fees. Anna finds him irritating despite working with her supervisor to consider some hypotheses about his underlying issues. After discussing the issue with her supervisor, Anna realizes that she tends to ignore the client when he is bragging instead of considering how to fruitfully address his maladaptive interpersonal behavior so that he can be more interpersonally effective one-on-one. After discussing the issue with her own psychotherapist, Anna realizes that the patient reminds her of her father, who also had some narcissistic traits. She realizes that she harbors resentment against both of them.

In the case of Anna in this vignette, it is likely that she is having more than one type of countertransference. Most psychotherapists would probably find the client's behavior irritating and off-putting. However, even supervision is not helping Anna cope with this, so it is likely that she is having a personal reaction as well. This type of strong idiosyncratic reaction to a client will happen to every psychotherapist sooner or later. This is one of the reasons why personal therapy is always wise for psychotherapists; it helps you in the process of understanding your emotional reactions to clients. To effectively treat this client, Anna will need awareness of her personal issues about her father and will need to be making progress in addressing these issues in her own personal therapy.

THE TERMINATING CLIENT AND THE ABANDONED PSYCHOTHERAPIST

Vince Robertson is a mental health trainee working in a college counseling center. He has been working with a client, Evan Lucas, for almost a year. However, termination of therapy is coming up soon since Vince is moving on to another training site. In addition, Evan has made significant progress in therapy, so he does not plan to continue with another psychotherapist. Vince finds himself feeling profoundly sad at the loss of the therapy relationship with Evan. He dreads the termination session and is starting to feel abandoned even though he is the one who is leaving. He finds himself tempted to encourage Evan to maintain contact with him, although he knows that this would be a boundary violation. Vince talks to his own psychotherapist about the issue. Together, they discuss Vince's personal issues of loss.

Researchers on countertransference have pinpointed termination as one issue that is likely to trigger countertransference reactions (Hayes et al., 1998). This book is about starting therapy rather than ending it. However, I recommend reading Kaner and Prelinger (2005) for a helpful discussion of the process of termination.

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