An Experience of Countertransference with a Civilly-Committed Sex Offender:

Using Art Therapy to Gain Self-Awareness and Understanding

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By:

Melissa Schoeberl

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Abstract

The hypothesis of this paper addresses the concept of utilizing art-making as a way to cope with and understand countertransference reactions in therapists. The writer contends by engaging in art-making, a heightened sense of self-awareness ensues in the therapist, and it is with this heightened awareness, that the dismantling of the countertransference hold on the therapist begins. Increased self-awareness by the therapist not only combats countertransference, but it also provides for a deeper understanding of why the countertransference took place, what unmet needs the therapist may be harboring, and provides the therapist with a wider scope of consciousness resulting in a more harmonious balance both professionally and personally. It is the writer’s belief that engaging in the creative process openly and sincerely will enhance sensitivity and responsiveness, shedding light onto the unmet needs of the therapist minimizing the effects of countertransference. This paper includes a review of literature which will define countertransference and identify four conceptions of countertransference: classical, totalistic, complementary and relational, and will examine unrecognized and unmanaged countertransference, and the associated costs to the therapist. The literature review will also examine how countertransference manifests itself differently while working with sexual offender populations, and will identify the importance of understanding and addressing countertransference with all populations. The last portion of this paper explores the role of art therapy and image-making in increasing self-awareness, specifically the author’s experience of countertransference and subsequent journey of awareness including the author’s courage to be imperfect.
Preface

“To free ourselves to develop our greatest human capacities, we must develop
the courage to be imperfect.” ~Rudolf Dreikurs, MD

Facing and attempting to unravel countertransference takes a willingness to be vulnerable, a feeling of exposure and insecurity, and most importantly courage. Courage is defined as “the ability to do something that you know is difficult or dangerous; mental or moral strength to venture, persevere, and withstand danger, fear or difficulty” (Merriam-Webster’s online dictionary, n.d.). This paper explains countertransference, how to use it with clients, and what could happen if it goes unrecognized and unresolved. In order to understand countertransference, one must be self-aware. It is one’s self-awareness that will define the feelings of countertransference, lessening their powerful hold and opening one to a greater understanding of not only oneself, but also to one’s clients.

I cannot begin to explain how I mustered up the courage to confront and better understand the countertransference I was experiencing, but also the courage it took to be vulnerable. I have carried feelings of inferiority with me through life, however, at the same time I have an unwavering courage, this feeling of “I can do anything”. I believe my feelings of inferiority contributed to my experience of countertransference, and my unwavering courage was the key to my ability to confront the countertransference resulting in a better understanding of what fueled it from the inside. Also, my inner courage brought resolution to my work with this particular client, and an openness and compassion to my own needs both professionally and personally.

Everyone feels inferior at some point in life, but it is a heightened sense of inferiority, often fostered by a misdirected upbringing which robs one of the courage to face challenges and that can result in a safeguarding retreat into neurosis (Terner & Pew, 1978). As humans, we are
born small, weak and completely dependent on others for our wellbeing which results in a feeling of inferiority. A sense of inferiority can transform us – igniting a need to strive for significance and importance, propelling a trajectory of horizontal movement through life. It is with this movement, we strive to understand our place in the world, and realize how we can contribute to our sense of being in a community with others. As humans we strive for something better. Some operate on the vertical plane never reaching a reprieve from their own sense of inferiority resulting in a striving for superiority over others and a decreased sense of social interest. In fact, for some, inferiority is compounded as they go through life. Consequently, this intensified feeling of inferiority is the source of all striving for significance, and for some this striving for significance can be a striving for superiority over others (Terner & Pew, 1978).

Engaging in the therapeutic process with clients requires the therapist to be responsible and aware of any countertransference reactions, and this is accomplished by an open sense of self-awareness; always keeping a pulse on the internal struggles, unresolved issues, biases and blind spots we all experience and bring with us as therapists. I believe we can all experience a heightened sense of self-awareness by engaging in the creative process even if we do not consider ourselves “artists.” We are all born creative, and it is this innate and instinctive sense of creativity that has kept us alive and thriving as human beings. We are all capable of art-making if we put our judgments and criticism aside and instead engage fully in the process with love, acceptance and compassion.

I shared my story of countertransference many times in peer groups, clinical supervision, with trusted friends and with my own therapist. At times, sharing the details of such a personal experience stirred up feelings of anxiety, self-doubt, insecurity and apprehension inside me, however I believe sharing my experience and showing my true authentic self (and all the subsequent emotional responses) is social interest in action. It takes strength to be vulnerable,
and as therapists we, of all people, should understand this as we expect our clients to be real and present and vulnerable every day. How can we expect our clients to be authentic, if we cannot ourselves? Vulnerability is a crucial part of understanding countertransference, and should be commonplace in clinical supervision groups. The process of reciprocal vulnerability between therapists and supervisors enables an atmosphere of safety and the possibility of having an impact on countertransference. It is my belief based on my own experience, that countertransference is not talked about adequately enough. It appears to be shied away from, as if talking about it means you are inadequate as a therapist, or you allowed it to happen, or you are weak-willed. I am sharing my experience of countertransference because I believe sharing my story lessens the power of the countertransference, and may inspire others to talk about their experiences. I am sharing to hopefully educate others on the importance of investing time in themselves; discovering our strengths and weaknesses as therapists and as humans; starting a dialogue around countertransference will provide a safe place for others to talk about their experiences. I am sharing to better understand myself, to create a feeling of community with others in my field authentically and openly; supporting and encouraging an environment in which we are students in our own lives, eager to learn about ourselves and the world in which we live, and remembering “life is not a state of being, but a process of becoming” (Terner & Pew, 1978, 41). Countertransference should be discussed during every clinical supervision group regularly and routinely. I will start the ball rolling by sharing what I was feeling and thinking as I experienced countertransference with a civilly-committed sex offender.

As a person, I am naturally striving for a sense of significance, while simultaneously harboring an overwhelming sense of inferiority. I believe my need for significance contributed to the countertransference I experienced. Looking back on my experience now, I feel the moment I saw this client I felt a connection of some kind. I felt this connection resonate through my body. I
was curious. I wondered if we knew each other in a past life as I was certain we did not know each other in our present lives. It was this curiosity that the connection and subsequent countertransference was born from. Something instinctual took place, something beyond my comprehension was at work, or at least that is how it felt. I felt a warmth from him despite the fact he was a sex offender, and this should have been my first clue that countertransference was taking shape. When I worked with this particular client, I felt empowered in helping him realize his potential; I felt a sense of importance almost as if I was the only one who could help him; the only one who could connect with him; I felt a bond to the client due to similar mistaken beliefs we shared and learned as children (fear of abandonment). I felt a deep connection with him over our similar childhoods, which naturally reinforced my feelings of countertransference; I felt trusted by the client, which gave me the feeling of importance (something I rarely allowed myself to experience but deeply longed for) and gave meaning to the work I was doing; I felt beautiful because of how this client looked at me, which gave me a sense of feeling worthy as a woman (based on the mistaken belief that I am only worthy if a man finds me physically attractive); I felt successful working with him; I needed to be needed in order to feel significant and I felt this client needed me in many ways. In many ways, what I felt from this client was love, and the experience had me questioning if I did not share the same feelings for him. A part of me did love him, and still does. The countertransference I was experiencing caused me emotional turmoil, but at the same time it felt good because many of my unmet needs were being met not entirely by this client specifically, but by the therapeutic space we had created together. Because I had an unmet need to feel significant in my life, I brought this need with me as I worked with this client resulting in countertransference, which is a completely normal and typical response as all therapists bring their life experiences, their beliefs about themselves and others and any unresolved issues into the therapeutic frame with clients. It is unavoidable. It is
going to happen to all of us at some point in our professional careers. While I felt shame at first for having experienced countertransference, I now understand how countertransference is part of the intimate process of therapy, and needs to be talked about more openly between colleagues and in clinical supervision groups.

While I have since terminated my professional relationship with this specific client, I do still think about him and what we experienced together often. I learned many facets of countertransference through my research, and through my professional experience, but the one aspect of countertransference I want others to understand is that countertransference does not end when the therapeutic relationship ends. It can live on, which means as therapists, we need to have the support and tools to continually keep our countertransference in check. Engaging in the art process has been the safe container I needed (and still need) to explore my countertransference. By creating art, I am able to unconsciously address my unmet needs, triggers and vulnerabilities thereby increasing my self-awareness. I gained so much by working with this client; he taught me so much about life, and about myself, but if I did not have self-awareness my story could have turned out much differently. I am forever grateful to him, the time we shared, and my experience of learning and understanding.
An Experience of Countertransference with a Civilly Committed Sex Offender: Using Art Therapy to Gain Self-Awareness and Understanding

Can engaging in the creative process be used as a way to explore, understand and gain self-awareness when experiencing countertransference with a civilly committed sex offender? Art therapists encourage their clients to use art-making as a way to understand themselves on a deeper more intimate level, to reconnect with parts of themselves they have neglected for whatever reason, to gain insight into past conflicts or trauma, and to foster self-awareness (American Art Therapy Association [AATA], 2014). Everyone brings their own unique perspective, based on past experiences and beliefs about themselves and the surrounding world to their relationships and therapists are no exception. Therapists bring their humanity, their unmet needs, their biases, fears and their life experiences with them into the therapeutic space as they work with clients. It is these unmet (and often unknown) needs in the therapist, and other vulnerabilities that can ignite countertransference (Gil & Rubin, 2005). The impact of countertransference is based on the therapist’s level of self-awareness, and his or her insight into his/her blind spots, biases and unrecognized emotional needs (Gil & Rubin, 2005). Participating openly and authentically in the creative process can bring a heightened sense of self-awareness therefore potentially limiting the impact of countertransference, and its effect on the therapist both professionally and personally. It is this writer’s belief that countertransference is inevitable and it is going to occur at some point. It is the responsibility of the therapist to identify and better understand his/her vulnerabilities as the therapist works closely with clients. Understanding oneself can be accomplished by participating in the creative process. Doris Arrington (2011) writes “when I have finished creating, I feel satisfied. Sometimes, I have understanding. I make art for beauty, education, grief and humor; I make art because that is how I solve problems” (p.108). It is this writer’s belief that engaging in art-making, one can accomplish a deeper
understanding of oneself resulting in a more attuned awareness of one’s countertransference reactions.

**What is Countertransference?**

The therapeutic alliance is constantly changing and growing as a result of the ongoing dynamic interchange between therapist and client. Both participants bring their life experiences, their beliefs about themselves and others, and their unresolved issues into the relationship, and each consciously and unconsciously influences the other, often in ways that are never known to either (McHenry, 1994). Consequently, both the client and therapist react to and influence the feelings, thoughts, wishes, projections, defenses, fantasized-selves and real-selves of the other. These reactions and influential reactions are the very nature of the transference and countertransference dynamic (McHenry, 1994). “Countertransference can manifest itself in a variety of ways but the most problematic occur when (a) therapists do not recognize the potential therapeutic benefits of countertransference and assume that all such feelings are to be avoided, (b) countertransference is poorly managed because of the therapist’s own unresolved issues, and (c) countertransference feelings turn into behaviors, particularly in the areas of sexualized or hostile behaviors” (Bearse, McMinn, Seegobin & Free, 2013, p.151). Freud (as cited in Hill & Williams, 2000) introduced countertransference to refer to unconscious and defensive reactions on the part of the therapist, typically in reaction to the transference of the client. Transference was defined as “the client’s manifestation of unconscious, unresolved, and conflicted patterns of interpersonal relationships in the therapeutic setting” (Hill & Williams, 2000, p. 685). Transference generally refers to the client’s unconscious transfer to the therapist of feelings and attitudes originally associated with important figures in early life, often a parental figure. When transference occurs, the client is unconsciously projecting past feelings, either positive and/or negative, onto the therapist. The client is reflecting back to past events unconsciously...
communicating verbally and non-verbally recreating these past events with the therapist. In most cases, “these past events range from those that focus on the person’s interpersonal experiences in early childhood to those that focus on the person’s interactions in later life” (Schwartz, 1978, p. 204). The emotional projection by clients of early relational patterns onto the therapist evokes a reaction from the therapist. This reaction to the client gives birth to countertransference. Countertransference is defined as the therapist’s reaction to the client’s transference; the concept of countertransference has expanded to include any and all of the therapist’s thoughts, feelings, and behaviors that may undermine treatment, and that arise in response to the client, the client’s family or even elements of the client’s ecosystem (O’Connor, 1991). During transference, clients act, talk, dream, emote and fully treat the therapist unconsciously from within patterns of previous relationships. Striving to be fully present in mind, heart, attention and feelings to their clients, therapists are affected by the impact of these old relational patterns and drawn into resonance with them. For the therapist, there is a real emotional experience that can become quite subtle, intense and complex. Each person in the dyad experiences the other one experiencing the same emotional experience (Parlow & Goodman, 2010). Simply put, when a therapist experiences a strong reaction—either physical, mental or emotional from a client, odds are the client is experiencing some level of transference resulting in countertransference in the therapist. Countertransference is subjective, much like the experiences and exchanges shared between client and therapist. Countertransference can be difficult to recognize and understand therefore making it difficult to assign a clear definition of it. According to Gelso and Hayes (as cited by Hayes, Gelso & Hummel, 2011) there are 4 conceptions of countertransference: the classical, the totalistic, the complementary and the relational.
The Classical

In this definition, countertransference is seen as the therapist’s unconscious, conflict-based reaction to the client’s transference. “Unresolved conflicts originating in the therapist’s childhood are triggered by the client’s transference and are acted out by the therapist” (Hayes, Gelso & Hummel, 2011, p.88). Within the classical perspective, countertransference is to be avoided, dealt with swiftly, and is considered detrimental to the therapist-client relationship (Burwell-Pender, & Halinski, 2008). Classical countertransference is viewed as those distorting elements that the therapist actualizes in the therapeutic frame. As Reid (1980) stated, “These are displacements onto the patient of emotional material which in actuality stems from the therapist’s internal representations of important persons from his (or her) own past” (p.78). From the classical perspective, countertransference is viewed as negative, inappropriate and often considered a weakness by the therapist; something the therapist must overcome and work against vigorously (Watkins, 1985). Fortunately today, a classical definition of countertransference is not widely held in the mental health field.

The Totalistic

A broader definition of countertransference is the totalistic view. According to this definition, countertransference represents all of the therapist’s reactions to the client. With totalistic countertransference, “all reactions are important, all should be studied and understood, and all are placed under the broad umbrella of countertransference” (Hayes, Gelso & Hummel, 2011, p.88). The totalistic approach considers all of the therapist’s thoughts, feelings and behaviors to be countertransference manifestations. Therefore, under this viewpoint, everything the therapist does or experiences is considered countertransference. According to Panken (as cited in Watkins, 1985) “the totalistic definition of countertransference is unduly amorphous, and second it is overly inclusive in scope” (p.356). With this viewpoint, the usefulness of the
countertransference concept is diminished; acquiring a vague, unspecific and meaningless quality. This limitless definition of countertransference eliminates its usefulness as a clinical construct. In other words, because all of a therapist’s reactions are considered countertransference in nature, countertransference is not considered a problem in therapy if used as a source of insight in the therapeutic dyad (Rosenberg & Hayes, 2002). The totalistic concept of countertransference is beneficial if used by therapists as self-investigation, and to further understand themselves and how they relate to their clients.

**The Complementary**

The complementary concept of countertransference is similar to the totalistic concept as all therapist reactions are considered countertransference, but with the complementary view, these reactions from the therapist are also considered to be a complement to the client’s style of relating (Hayes, Gelso & Hummel, 2011). This concept of countertransference, when properly managed, can be beneficial to the therapist in understanding their clients and how they navigate relationships. Strictly speaking, the client exhibits certain “pulls” on the therapist. The well-functioning therapist does not act upon these “pulls” (even though it is the typical and expected reaction elicited in others by the client), but instead seeks to understand what the client is doing to stir up these reactions which leads to an awareness of the client’s interpersonal style of relating (Hayes, Gelso & Hummel, 2011). With the complementary identification of countertransference, the client unconsciously assigns a role to the therapist, and as such the therapist adopts the assigned role and treats the client accordingly.

**The Relational**

In this concept of countertransference, the needs, unresolved conflict and behaviors of both the client and the therapist are believed to contribute to the manifestation of countertransference (Hayes, Gelso & Hummel, 2011). It is the enmeshment of the client’s
dynamics or transference, and the therapist’s needs, struggles and vulnerabilities that spark relational countertransference. Relational countertransference is understood as jointly created between therapist and client.

Having experiences of countertransference can and often do evoke feelings of shame among therapists both seasoned and novice. Without fully understanding countertransference, a therapist can feel as though they did something wrong or perhaps the therapist “allowed” the countertransference to take shape. As a result of these misconceptions, countertransference is often hidden due to the assumption that if a therapist experiences feelings of countertransference, then he or she is an unethical or an inadequate therapist. This attitude discourages therapists from discussing feelings of countertransference with other therapists or in supervision often resulting in countertransference becoming taboo (Burwell-Pender & Halinski, 2008). While one therapist may have the self-awareness and self-knowledge to know something is being “pulled” or triggered by a client, others unfortunately do not have the same awareness making countertransference potentially harmful to both the client and therapist instead of it being an opportunity for growth and self-discovery. There can be a stigma attached to disclosing countertransference with colleagues or in a professional supervision group setting. This stigma comes from a fear on behalf of the therapist that he/she did something wrong. There can also be a fear of being viewed as incompetent as a therapist by clinicians or supervisors when disclosing countertransference. Countertransference is only harmful when the therapist’s emotional (and physical) responses remain out of consciousness and when they are acted on (Ligiero & Gelso, 2002). It is the responsibility of the therapist to be aware of and monitor these responses however they may manifest themselves as a means to prevent countertransference from forming.
Unrecognized and Unmanaged Countertransference

Countertransference is, in fact, “a most powerful force, and if it remains an unrecognized element, it can be also be very dangerous” (Kraemer, 1958, p.30). Given the potential to undermine treatment of the client, it is the therapist’s responsibility to recognize and manage countertransference through verbal disclosure, and heightened self-awareness (Gil & Rubin, 2005). The impact of countertransference can be manifested through the therapist’s blind spots, biases, and unrecognized emotional needs resulting in inappropriate emotional and behavioral responses, intolerance, need to be liked by the client or attempts to change the client (Landreth, 2002).

O’Connor (1991) cautioned therapists to monitor their countertransference so that they could avoid frustration, savior fantasies, over identification with their clients and burnout. Monitoring countertransference can include therapists seeking their own mental health treatment. However, there are many barriers to mental health professionals seeking their own treatment. Therapists who seek individual treatment may be viewed negatively not only by family and friends but also by clients, employers and colleagues who may question the ability of the therapist who is struggling with his or her own psychological distress (Bearse, McMinn, Seegobin & Free, 2013). Privacy concerns can also prevent a therapist from seeking treatment. Though mental health professionals know ethical standards and state laws regarding protected health information, they have likely also experienced other mental health professionals who take these standards lightly and casually and perhaps wonder how fiercely their personal therapist will honor privilege and confidentiality standards (Bearse, McMinn, Seegobin & Free, 2013). Therapists strive to eliminate barriers that prevent clients from seeking mental health care. Unfortunately as a profession, value is not necessarily placed on therapists seeking their own mental health treatment for many reasons. Understanding countertransference is crucial to the
success of treatment provided, and one way for a therapist to dismantle countertransference is through seeking his/her own mental health counseling.

When therapists learn to appropriately identify, normalize, and work through feelings of countertransference, managed countertransference ensues. Gorkin stated (as cited in Yeh & Hayes, 2011) contemporary theorists argue that by examining one’s countertransference reactions, therapists may be able to deepen their empathy toward clients, develop insight about clients, offering clients a sense of universality by virtue of sharing a common experience, and provide hope to clients that problems can be resolved. In one sense, all therapists have had painful experiences, have confronted adversity or have experienced physical or emotional suffering, and therefore have some degree of impairment. It is with our own suffering that prepares us to appreciate the suffering in others; the therapist’s own past or present pain can facilitate empathetic connection with clients and the positive use of countertransference in therapy (Zerubavel & Wright, 2012).

When a therapist is unaware or unwilling to examine and work-through feelings of countertransference, countertransference is considered unmanaged. No matter what school or type of therapy one embraces, it is widely acknowledged that it is the nature of the relationship and the interactions within it that are the primary determinants of change, no change and in some cases deterioration (McHenry, 1994). Crucial to the nature of the therapeutic alliance are recognizing, acknowledging and understanding the numerous transference and countertransference interactions. Failing to realize, and be aware of the transference and countertransference influences on the therapeutic relationship, the therapist risks not only the integrity of the therapeutic alliance, but could end up compromising any change taking place by the client. These dilemmas affect not only the client’s sense of self, but also the nature of the therapeutic alliance and the outcome of treatment (McHenry, 1994).
Understanding and Addressing Countertransference

Understanding the numerous transference and countertransference interactions between client and therapist is crucial to the nature of the therapeutic relationship. A therapist’s unresolved conflicts will only lead to countertransference reactions when he/she is somehow triggered by the client and research clearly indicates that client factors, in and of themselves do not predictably cause countertransference reactions (Rosenberger & Hayes, 2002). To understand one’s unresolved conflicts, it is the personal and professional responsibility of the therapist to “know oneself internally—know how one functions, why one feels and thinks and behaves as one does” (Rubin, 1984, p. 58). When analyzing countertransference, the therapist must find a way to use the initial countertransference affect as a guidepost. This might be a sense of calm, soothing pleasure, intense irritation, a deadened emotional state or any other irregular state of mind that can help to alert one to the presence of something or someone trying to take up residence in one’s mind. Even if it feels good, this countertransference feeling is an alien presence that is not self (Waska, 2011). Examining countertransference can bring new insights into the therapeutic dyad which can strengthen the connection between therapist and client. By understanding one’s countertransference reactions, therapists may be able to deepen their empathy toward clients, develop insights about clients, and provide hope to clients that problems can be resolved (Yeh & Hayes, 2011). Nouwen stated (as cited in Yeh & Hayes, 2011) “a deeper understanding of one’s own pain makes it possible to convert weakness into strength and to offer one’s own experience as a source of healing to those who are often lost in the darkness of their own misunderstood suffering” (p.322).

The therapist’s own inner awareness is of utmost importance and greatest defense when working with countertransference. Judith Aron Rubin (1984), a well-known and respected art therapist, believes “knowing oneself well enough to spot one’s countertransferential distortions is
probably the most difficult area of all, despite one’s familiarity with the topic” (p. 108). When a therapist lacks self-awareness, purely theoretical conceptualizations of one’s clinical work appear to be insufficient for managing countertransference. Decoding countertransference begins with self-awareness, and the therapist taking his/her awareness of the countertransference, and attempting to understand what is fueling it from within. Freud believed (as cited by Gail King, 2011) personal therapy was the deepest and most rigorous part of anyone’s clinical education. In Freud’s model, the work of the analysis is to make the unconscious conscious, and Freud doubted that any analyst could help a client realize this goal if he or she could not do it for his/herself. He considered that an unanalyzed analyst could go only as far as his or her own limited experience of the unconscious permitted him/her to go, and so regarded personal analysis as not only desirable, but essential. With increased self-awareness comes increased understanding of transference and countertransference phenomena.

In traditional psychoanalysis, countertransference is addressed and resolved through the therapist’s own analysis (Gil & Rubin, 2005). A therapist can gain a deeper understanding of him/herself personally, but also a better understanding of who he/she is professionally, which aids in identifying countertransference. Many theorists in mental health including Sigmund Freud, Alfred Adler and Carl Jung sought relief from their own emotional suffering (Cain, 2000). A therapist engaging in his or her own therapy can aid countertransference dilemmas or disasters, by establishing greater professionally relevant self-awareness and better professional functioning. Engaging in the practice of therapy demands that the therapist be able to experience an ongoing inner dialogue of what is at times painful self-scrutiny; moreover, the observing ego of the therapist must be able to constantly ask and answer the question, “Why am I saying (or doing) this right now with this client?” (McHenry, 1994, p.569). Existing literature focuses on nonspecific verbal techniques designed to help the therapist develop awareness, insight, and self-
understanding through reflection, supervision or treatment (Robbins & Jolkovsky, 1987; Rosenberger & Hayes, 2002; Sarles, 1994). To understand countertransference, one must be willing to talk openly and honestly with colleagues, a supervisor or with a therapist as part of seeking mental health treatment. It takes a willingness to be vulnerable. Often countertransference is presented in a negative light due to the psychoanalytic language of the concept or of the ethical dangers that can arise out of countertransference including the implications of sexual misconduct (Burwell-Pender & Halinski, 2008). Clinical supervisors must illuminate issues of countertransference and provide a safe environment to normalize the experience; furthermore, clinicians need to better relate and support each other through countertransference especially since clinicians work so closely together on a daily basis and can know each other on a more intimate level. Understanding countertransference takes initiative and an investment of time and energy into oneself. Therapy and other forms of personal growth work can assist in securing support for the emotional tolls of countertransference, and other personal reactions to the clinical material which can reduce potential burn out, and increase overall job and life satisfaction.

**Sex Offenders and Countertransference**

Sex offense counseling can be defined as providing face-to-face evaluation and counseling to presentence, post sentence or convicted sex offenders in jails, prisons or community treatment centers. Typically, therapy has been and continues to be provided from a cognitive-behavioral orientation through group and individual therapy with an emphasis on containment of the offender and risk management rather than curing the problem (Dreier & Wright, 2011). A therapist treating sex offenders needs to learn how to delicately balance engaging with disturbing stories of sexual offending while at the same time maintaining an empathetic relationship with the client, which can be problematic for some clinicians. The
population of sex offenders in treatment is predominantly male and the offenses involved may range from statutory rape charges following consensual sexual contact with a peer to pedophilia, sadism and other violent crimes (Center for Sex Offender Management [CSOM], 2013).

The sparse amount of literature that has investigated the impact of working with sex offenders describes it as mentally, physically and emotionally draining (Scheela, 2001). Furthermore, Scheela (2001) contends “therapists are warned of a high risk for personal and professional burnout” (p.750). Therapists experience persistent and intrusive images of sexual abuse through the work they do with offenders. McCann and Pearlmann (1990) have labeled the experience of these disturbing and intrusive images “vicarious trauma,” which they define as “the result of being exposed to traumatic material indirectly through client experiences shared with therapists, which can change therapists’ beliefs and expectations of themselves and others” (pp.360). Therapists working with offenders are reminded daily how unsafe the world is, leading to thoughts of being vulnerable to violence and as a result are often times less trusting of other people. Given the high stress environment, and graphic detail of offense and criminal histories presented by the clients, therapists working with offenders experience strong feelings and thoughts in relation to their clients often resulting in equally strong response of countertransference (Watkins, 1985).

Countertransference experienced while working with sex offenders can be powerful, intimidating and discouraging. Whereas transference and countertransference are well documented in the literature regarding general psychotherapy, they tend to involve other characteristics when the clients are sex offenders. There are four identifiable ways in which sexual offenders may transfer feelings onto the therapist, consequently evoking a strong countertransference response from the therapist (Allen & Brekke, 1996). These processes include intimidation, imitation, seduction and invalidation of the therapist. In regard to
countertransference, it has been found that therapists sometimes experience symptoms of trauma typically associated with being victimized, and these countertransference processes may also resemble symptoms of post-traumatic stress disorder/injury or rape trauma syndrome (Allen & Brekke, 1996). Complicated feelings of countertransference can be heightened especially if the therapist has unresolved issues of his/her own victimization that he/she has not properly identified or addressed. Clinicians “who have a past history of sexual abuse may experience intense feelings in themselves and suppressing them would lead to greater transference-countertransference problems” (Pais, 2011, p. 90).

Boundaries play an important role in working with sexual offenders. Maintaining professional boundaries is critical in every working relationship, though it takes on added significance in work with sex offenders. Given the sexual content of the information that is shared between the client and the therapist, such disclosures are intensely personal, intimate and obviously sexual. For most people, topics related to sex and sexual encounters evoke strong feelings, including arousal and therapists are no exception. Such countertransference reactions, especially if unknown by the therapist, may lay the foundation for boundary violations to take place. As with other marginalized or challenging client populations, managing countertransference may be more difficult for the therapist to maintain (Grady & Strom-Gottfried, 2011).

Therapists working with sex offenders struggle internally with responses and feelings that are considered largely unacceptable professionally and culturally. Countertransference feelings and thoughts can, and often do, include “positive” sexual arousal by the therapist, and these disturbing reactions may contribute to disastrous consequences, including the ultimate ethical violation of sexual involvement with the client (Gerber, 2008). Both sex offenders and the therapists who treat them come to the therapeutic relationship as sensual, sexual beings. It is
imperative the therapist be diligent in both identifying and resolving any sexualized reactions or countertransference experienced when working with clients. Unfortunately, sexual thoughts and feelings elicited in working with sex offenders are rarely acknowledged or discussed during formal or informal exchanges between clinicians or clinical supervisors. Censoring or compartmentalizing thoughts or sexualized physical reactions compromises the therapeutic process and growth (Gerber, 2008). Furthermore, unwarranted feelings of shame or guilt on the part of the therapist are resulting in even less discussion around emotional or sexual reactions from clients.

An Adlerian Perspective of Countertransference

According to Alfred Adler, every idea that is accepted by an individual is screened through his or her own life style – the characteristic way that one acts, thinks, perceives and the way one lives helping to find one’s place in the world. The life style is built in childhood on deeply established personal beliefs or constructs referred to as private logic (Carlson, Watts & Maniaci, 2006). Followers of Adlerian psychology believe all people are trying to find their place in life, using their private logic to determine what is right and wrong on the basis of their own subjective experiences (Mosak & Maniaci, 1999). Therapists bring their lifestyles to therapy and use them for their understanding, anticipations and coping with life; in Adlerian therapy, this is the countertransference (Mosak & Fasula, 2011). Both transference and countertransference are artifacts of therapy and may affect the therapy in positive and negative ways. There was and still can be a belief developed by Adlerian psychologists suggesting all countertransference is negative, and should promptly be addressed and resolved. However, according to Adler’s psychology of use, both transference and countertransference may occur or be acted out on the useful or useless side of life (Mosak & Fasula, 2011).
Current literature shows two schools of thought regarding transference and countertransference existing in Adlerian psychology – one group of Adlerian therapists believe the Freudian idea of transference and countertransference does exist within the realm of Individual Psychology. Adlerians in this camp believe the idea exists because all relationships include some feeling about the other person. This group of Adlerian psychologists treat the transference or countertransference as a lifestyle issue regardless of whether it is positive or negative (Mosak & Fasula, 2011). In Individual Psychology, lifestyle is congruent with the term personality in other psychological systems but is contrasted to them not least because of its emphasis on the person’s characteristic way of movement. Movement is described as all thoughts, feelings and physical activity; movement connotes the understanding of the human being as always in process (Griffith & Powers, 2007). A person’s rationale for such movement may be different than the movement itself, but as Adler often stated “trust only movement for that tells one people’s true intentions” (Mosak & Maniaci, 1999, p.86). Understanding and witnessing one’s movement with regard to transference and countertransference takes self-awareness and an openness and courage to understand one’s motivations and vulnerabilities.

The other group of Adlerian therapists find the concept of countertransference to be unacceptable because it implies a superior role for the therapist over the client. Adler stated (as cited by Ansbacher & Ansbacher, 1956) “the psychotherapist must lose all thought of himself and all sensitiveness about his ascendancy” (p.341). Adlerian therapists in this group believe a good therapeutic relationship is a friendly one between equals (Mosak & Maniaci, 1999). Although these Adlerian therapists do not ascribe central importance to countertransference as a therapeutic construct, they do acknowledge that countertransference could deter from the therapeutic relationship (Tobin & McCurdy, 2006). Adlerian therapists in this group do not focus
on whether countertransference is occurring or not; they focus on “the collaboration and interaction between client and therapist” (Tobin & McCurdy, 2006, p. 154).

**The Art of Art Therapy and Countertransference**

The field of art therapy currently defines itself as a mental health profession in which clients, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety and increase self-esteem (American Art Therapy Association [AATA], 2014).

Countertransference manifests itself in innumerable ways, but there are a few that are specific to art-making with clients. Harriet Wadeson (1987) believes “communication through the art made by the art therapist during session may become a countertransference vehicle” (Wadeson, 126). Art therapy is an exploratory process that enables the client to reflect upon the past and its influence on the present and on the future. When an art therapist is engaging in the creative process with his/her client, the artwork made is going to encourage the maker to connect with his/her true thoughts and feelings intimately. A therapist lacking in self-awareness or conscious wakefulness can inadvertently express personal and private thoughts and feelings without a proper filter ultimately leading to countertransference.

Whether one uses paint, pencils, photos, fabric, yarn, metal, clay, chalk, pastels or wood matters very little; what is important is the use of all aspects of oneself, including the artist inside, as a means of understanding and greater self-awareness (Rubin, 1984). Without a heightened sense of self-awareness, a therapist may unknowingly put clients in a position of competing for her or his attention as a way to satisfy her or his own needs. It is imperative a therapist be aware of his/her unconscious fears, mistaken beliefs and any unsettled issues which could potentially be triggered when working with clients resulting in countertransference.
Anxiety may play a role in the emergence of countertransference specifically with art therapists. This anxiety is generated by a need for the therapist to be in control resulting in an over-structuring of the session. Rather than being responsive to clients’ needs, the art therapist may plan activities in advance without being sufficiently flexible to adapt to immediate conditions and needs (Wadeson, 1987). Some art therapists prefer to employ strict art directives based on their own anxiety levels, and not necessarily the best interests of the clients with whom they are working. Anxiety can often stem from the unpredictability of therapy sessions, and by using strict directives with clients rather than a “wait and see” approach, the art therapist is attempting to feel less anxious. While countertransference can develop when the therapist attempts to lessen his/her anxiety, countertransference can take shape with the therapist’s altogether avoidance of his/her own anxiety or their client’s anxiety (Gil & Rubin, 2005). It is important for the art therapist to focus on the client’s involvement in the work, choosing and facilitating art activities that are helpful to the client and assisting the client to find meaning in the creative process (Malchiodi, 2003). Whether or not one senses countertransference reactions, the therapist should always try to keep in touch with whatever is stimulated by clients. It is a source of further self-knowledge, but it is also a source for better understanding the people with whom one works (Rubin, 108). Every mental health professional comes to the therapeutic encounter with a backlog of fears, aversions, repressions and dislikes that certain clients can arouse resulting in countertransference. In order to maintain the integrity of the therapeutic work, therapists must recognize and manage their countertransference responsibly.

Very often art illuminates the space between client and art therapist, therefore also illuminating unconscious aspects of the relationship shared between the two (Schaverien, 1999). As a therapist who is also an artist, the art therapist will inevitably have his/her own personal aesthetic interests and preferences which will influence and inform any countertransference
taking shape (Schaverien, 1999). The artwork made by clients may seem to be very skilled, beautiful or seductive, or alternatively it may repulse, appear unskilled or horrific. Regardless, the artist-self of the therapist may respond by taking pleasure in the presentation of the client’s artwork influencing both the production of the artwork and its presentation. All such responses may be understood as aspects of countertransference, and potentially reflect the depth of the therapist’s engagement (Schaverien, 1999).

Because of the interactive nature of art therapy, which often involves the provision of materials and the giving of assistance, a client may use art expression to project feelings about the therapist; there may also be countertransference on the part of the therapist because of taking on the role of nurturer and provider in therapy (Malchiodi, 2007). Engaging in the art-making process can cause regression in some clients or trigger feelings of inadequacy based on past childhood experiences. It is critical for the therapist not to adopt the role of nurturer in therapy, but instead kindly encourage the client during the art process. If the therapist can be aware of his or her own feelings of inadequacy, as their clients are experiencing theirs, the therapist will not overly nurture or placate the client reducing the likelihood of countertransference from taking shape. A responsible art therapist notes her own strong or puzzling feelings in relation to a client or any unexpected behavior on her own part (Wadeson, 1987).

Clinical supervision puts the transference and countertransference relationship and associated feelings at the center of practice which can help therapists think about their feelings and digest them in a way that makes use of them as evidence rather than discarding them as purely subjective (Evans, 2007). Supervision also affords a golden opportunity for examining feelings and fantasies, making meaning of the intersubjectively determined experiences of the client and therapist who are immersed in the process of therapy (Southern, 2007). Ultimately, supervision is an opportunity for therapists to reflect on their therapy work, broadening and
deepening understanding of their clients in a safe environment. Ideally, clinical supervision is an environment of non-judgment, and a space where clinician’s can seek reflective attention to one’s internal responses in the clinical situation from other clinicians, and a dialogue can take place making use of these responses as a tool for understanding.

**Art As Therapy for Countertransference**

“In art, you tell the truth. In art comes the truth, but it comes in a way that touches you immediately not intellectually” - Edith Kramer

Edith Kramer, one of the founding pioneers of the field of art therapy, emphasizes the healing properties of art-making, its potentiality for aiding integration and synthesis, its role in sublimation and the resulting lack of necessity for verbal interpretation or insights (As cited in Wadeson, 1987, 259). Creativity is a process of perception, the interaction of unconscious and conscious modes of thinking; image-making is a concrete creative expression making visual equivalents for otherwise unspoken inner feelings. This psychodynamic process facilitates self-awareness through reflection on the imagery produced thus influencing behavior and social functioning, (Wylie, 2007). By this process, the self is externalized; communicated through creativity, emotion is viewed in imagery, interpreted and acknowledged (Wylie, 2007).

Robbins and Jolkovski (1987) noted that the most effective ways to deal with countertransference included awareness, understanding, alertness, and implementation of a theoretical framework, along with an investigative approach to self-awareness; however, they did not specify how to use these means. The act of creating art can be “the investigative approach to self-awareness” needed to address countertransference. Aside from verbal disclosure to understand countertransference, Harriet Wadeson (1987) states “Art therapists also have another very potent resource as well- their own artwork” (pp. 126). Art is a powerful tool in communication, and art expression is a way to visually communicate thoughts and feelings that
are too painful or confusing to put into words. Creative activity has also been used in
psychotherapy and counseling not only because it serves another language but also because of its
inherent ability to help people of all ages explore emotions and beliefs, reduce stress, resolve
problems and conflicts, and enhance their sense of well-being. Furthermore, art therapy supports
the belief that all individuals have the capacity to express themselves creatively and that the
product is less important than the therapeutic process involved (Malchiodi, 2003). A therapist
encourages their clients to utilize art-making to alleviate stress, express difficult emotions, gain
awareness and self-understanding. Sometimes they fail to invest the time in their own art-making
for self-processing not only with the clients they work with, but with their own internal struggles
and weaknesses.

Existing literature focuses on nonspecific verbal techniques to assist the therapist in
developing awareness, insight and self-understanding as a way to articulate and comprehend
countertransference. The emphasis on intellectual and verbal means as a way of addressing and
resolving countertransference is not necessarily a problem, particularly when the treatment is
predominantly verbal (Gil & Rubin, 2005). However, traditional verbal therapies for addressing
countertransference may not be optimal for those practicing art therapy because art therapy is not
exclusively dependent on the verbal elements of traditional therapy, which are discussion,
inquiry and interpretation. It is logical for a therapist utilizing art with clients as a modality for
growth and change, to also use art-making as a way to gain professional and personal awareness,
isight and understanding around countertransference reactions (Gil & Rubin, 2005).

In interviews with art therapists who made post therapy session art, Kielo (1991) found
that most saw their artwork as helpful in aiding empathy and clarifying confusion. Judith Rubin
(2005) wrote “it is helpful to use one’s artist-self as a tool for reflecting on what one is
experiencing in response to a particular client or group; using art media to represent the
individual or the feelings and fantasies they evoke is a most powerful way of reflecting on one’s inner experiences” (p. 108).

Art therapist Edith Kramer proposed that the healing potential of art making stemmed from the ability of creative work to activate certain psychological processes; although art expression cannot directly resolve conflict, it can provide a place where new attitudes and feelings can be expressed and tried out (Malchiodi, 2003). The creative process is a dialogue with the self. The development of intense, positive countertransference feelings toward a client can be a threatening, guilt-provoking experience especially for the inexperienced clinical worker. As a result, many art therapists respond to material that comes up in their therapy work by creating artwork privately, with clients or as part of clinical supervision. Barbara Fish (2012) contends it is “this artwork that may be used for self-care may support empathetic engagement with clients or may illuminate countertransference” (p.138).

**Spontaneous Expression to Understand Countertransference**

The art product remains in the therapeutic space as a document of the internal experience (Gerber, 1994). Being human means one brings his/her humaneness with him/her – the compilation of life experiences, beliefs about oneself and others, and any unresolved issues one may have. Clients also bring their own unique stories to the therapeutic frame, and it is the alliance with clients along with the therapist’s humanity that enriches the space, but also potentially creates an ideal environment for countertransference to take place. The most obvious and customary use of art in response to clients is the spontaneous reaction, especially when strong feelings have been aroused in the art therapist or if he or she is pondering a puzzling clinical issue; spontaneous responses provide insight and recognition of unconscious processes (Wadeson, 1987). Spontaneous expression is ideal for dealing with countertransference, since both spontaneous expression and countertransference are unconscious processes.
Spontaneous art or spontaneous expression refers to drawings, paintings, or other art forms that are created without any preconceived notion of what one is going to make (Malchiodi, 2007). This technique allows each image to come quite naturally and organically almost always with a heightened emotion (Rubin, 1984). Therapy is an exploratory process, as is the use of spontaneous expression which provides an opportunity for the client to discover and understand his/her own ideas and feelings free from limitations of an art therapy based directive. Spontaneous expression allows the client to freely explore not only internal images, feelings, thoughts, and ideas, but gives the clients a chance to explore and play around with art materials without restraint or boundaries. The creative process for anyone must grow out of such a free exploration of possibilities; this kind of playful experimentation is an essential element in genuine creative work of any sort (Rubin, 1984). There are no rules with spontaneous expression; anything is possible.

Spontaneous expression has strongly influenced the field of art therapy, and is based off of a psychoanalytical process called free association. In this process, clients say whatever comes to mind without self-censorship. Sigmund Freud is credited with developing this technique, which he employed to increase his understanding of how images, particularly those in dreams, were connected to the lives of his clients (Malchiodi, 2007). Clients using free association report their feelings, experiences, associations, memories and fantasies to the therapist often times lying on a couch which encourages deep, uncensored reflections and reduces stimuli that may interfere with getting in touch with internal conflicts and productions (Corey, 2009). Spontaneous expression is free association with imagery; traveling from one creation to the next with no deliberation. There is no logic behind the image-making, no striving for perfection, and no concern over image cohesiveness. As a result of the influence of free association, spontaneous art making became fundamental to the process of art therapy, because it encourages both uncensored
symbolic communication and authentic expression; it is the optimal route to the unknown and/or the repressed which often spark countertransference (Malchiodi, 2007).

Summary

Gura Gita, a Sanskrit prayer, says, “One who thinks he knows not, knows; one who thinks he knows, knows not...” (n.d.). With understanding countertransference, comes a need to be open, authentic and vulnerable. According to Hayes, Gelso and Hummel (2011), “countertransference will inevitably occur; this is so because all therapists, by virtue of their humanity, have unresolved conflicts, personal vulnerabilities, and unconscious soft spots that are touched upon in one’s work” (p.89). Therapists have an enormous responsibility to be not only skillful, but also professionally responsible, which includes being self-aware of one’s internal processes and motivations (Burwell-Pender & Halinski, 2008). Furthermore, the therapist must have an ongoing internal dialogue evaluating any and all unresolved issues, biases and vulnerabilities. The attention the therapist pays to his/her emotional health as well as physical responses to clients and working through unresolved issues will provide an environment in which self-awareness is optimal. Participating in artistic expression and image-making is a healthy and constructive response to countertransference, and can provide a platform for heightened consciousness and greater understanding of the self. Perpetual self-awareness and responsiveness is the best defense in minimizing countertransference from taking shape. Countertransference will accompany therapists as they form intimate, constructive therapeutic relationships with clients. Humans inevitably bring humanity with them to the therapeutic relationship, however by engaging fully and genuinely in the creative process they can achieve a heightened sensitivity and responsiveness to their own unmet needs. By understanding those unmet (and often unknown) needs, therapists minimize the effects of countertransference at the same time broadening their scope of self-awareness optimizing their potential both
professionally and personally. The goal as therapists is to provide a platform for clients by encouraging them to engage in the creative process as a way to better understand themselves and their needs more clearly, to reconnect with parts of themselves they have neglected due to past conflicts or trauma, and to foster greater self-awareness. By giving themselves what they strive everyday to give their clients therapists will not only provide a richer therapeutic environment with greater competency, but they will be better equipped to identify and successfully address the complexity of countertransference.
References


Appendix

My experience of countertransference was like a powerful storm developing slowly and methodically over time eventually kicking up many of my unmet needs and vulnerabilities. Knowing how difficult this experience has been for me, I relied heavily on my art-making to get through it. I’ve included a sample of the art I created in response to countertransference as completing this paper (and experience) without it, didn’t seem right.

I created “Trees” (Figure 1 & 2) when I first started expanding my awareness of my vulnerabilities and blind spots. The countertransference was just beginning.

Figure 1 and 2, “Trees”, 2012

“Beginning” (Figure 3) was/is an emotional piece for me. I see myself and see the client coming as close as we possibly can, but not touching; keeping the therapeutic frame intact.

Figure 3, “Beginning”, 2012
As I ended the therapeutic relationship, it was very important to my client that I remember his birthday. He clearly wanted to be remembered by me, if only for one day. I created the next 4 images “Untitled” (Figure 4, 5, 6 & 7) on his 56th birthday.

Figure 4, “Untitled”, 2013

Figure 5, “Untitled”, 2013
Figure 6, “Untitled”, 2013
Figure 7, “Untitled”, 2013

It’s always been difficult for me to “sing my own praises”. This process brought out a courage I did not know I had. It takes courage to be real and vulnerable and true to what you are experiencing even though some might not understand. The courage inside is what allowed me to keep talking about it.

Figure 8, “Know Thyself”, 2013
I created “Know Thyself” (Figure 8), and “Inside?” (Figure 9) to represent the process of understanding myself on a deeper level. Before this experience of countertransference, I thought I had more self-awareness than the average person. Now, I realize I had no idea what self-awareness meant, and today I feel more well-rounded as a person (and therapist).

While countertransference brought me greater self-awareness, it also made me feel like my head was going to explode most of the time. I was feeling apprehension; “high” from having unmet needs finally met, confusion, anxiety, adornment, and shame all at the same time. I created “Your Brain on Countertransference” (Figure 10) to represent the turmoil I was experiencing.

Circular images feel safe to me, and I found I defaulted to them often throughout this process. I feel like I could just fall right in the center of “Untitled” (Figure 11, 12, 13 & 14), and spin around and around. I really appreciate the movement of these images.
The hearts in “Mine” (Figure 15) and “Yours” (Figure 16) represent our humanity. My client and I came from very different places, experienced many different things. He’s a civilly committed sex offender in treatment for an indefinite amount of time. I’m a wife, a mother and a professional just embarking on a new career. No matter our differences, there was a connection, and the connection was our humanity. Two people connecting on a human level; learning from each other and aspiring each other.
I put it off as long as I could…the portrait. I knew it was going to be challenging, and emotionally draining to gaze at his “photo” (the only image I had was his mug shot which was available on the internet). In “Profile I” (Figure 17), and “Front I” (Figure 18), I chose blind contour to capture his image. It felt safe as I was concentrating on a line and a shape, not his image. I was looking through his image, not directly at it. When I finished these two images, while I like what I created, the images felt too polished, too pristine, and faultless almost. The art process which created the images felt tight, and constrained. I wanted to be free.

“Profile II” (Figure 19) captures my attempt at incorporating a freer feeling with my client’s image. I still chose blind contour drawing; however with this piece I completed 3 drawings on top of each other, and outlined each drawing in marker. This image appears to have more movement compared to the previous two.
In “Front II” (Figure 20), I continued with blind contour but chose to use colored pencils and instead of shading, I focused on the thickness of the lines to create shading. I layered 8 contour drawings to create this image.

I wanted to incorporate yarn in my art-making, and was excited about the idea of merging contour drawings and yarn together. “Untitled” (Figure 21) is controlled encapsulated by thin lines of colored pencil and strands of yarn glued tight.

“Eye” (Figure 22) evokes such a raw emotion in me. I can feel this client’s hopelessness, sadness, eternal longing for a “normal” existence. He wants a chance for a life. He’s tired. He’s broken.
“Me” (Figure 23) is the only self-portrait in my collection. It encompasses many layers of countertransference; confusion, intimidation, admiration, fear, pleasure and authentic care and compassion shared between two people. I see an inexperienced graduate student on the outside, but on the inside I feel a mastery of countertransference having lived and breathed it. I feel full of wisdom, emotional intelligence, awareness and competence. I know myself on a deeper, more intimate level. I’m aware of important needs that I denied and buried years ago. The greatest gift I received is I’m no longer ashamed of my needs. I am aware of and understand them, which is an important (and necessary) gift as a therapist. I relish these feelings and am forever grateful for this experience.