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# Developing countertransference awareness as a therapist in training: The role of containing contexts

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The psychodynamic literature suggests that countertransference is an inevitable part of therapy and a significant feature of the client-therapist relationship. However, countertransference is also considered to be a 'double-edged sword': when it is reflected on by the therapist, it can offer valuable insights into the therapeutic relationship, but when it remains outside of awareness and therefore unmanaged it can result in the therapist unwittingly acting out in the therapeutic relationship and responding in counter-therapeutic ways. The purpose of this research was to explore the factors involved in the development of countertransference awareness in therapists and to construct a grounded theory of the process. Fifteen qualified therapists were recruited and interviewed, either face to face or via Skype, using a semi-structured interview schedule. The grounded theory constructed from the data suggests that during training participants initially experienced countertransference as threatening and overwhelming. When this experience was contained in supervision and therapy, the organisational context and by participants' theoretical framework, they could reflect on their countertransferential responses and make sense of their experience, which then developed their self-awareness and other insights to the benefit of the therapeutic relationship. Conversely, a lack of containment in these domains resulted in participants acting out their countertransference and becoming either over or under available in the therapeutic relationship. The findings offer a useful process model on the role containing contexts play in the development of countertransference awareness for therapists in training.

**Keywords:** Countertransference; containment; therapists in training; supervision

## Introduction

### *The construct of countertransference*

The construct of countertransference, broadly defined within the literature as the therapist's responses towards the client, both conscious and unconscious, has undergone several modifications within psychoanalysis (Bichi, 2012). Freud (1910) initially regarded countertransference as the analyst's emotional reaction to the client's transferences and argued that it needed to be overcome lest the analyst become emotionally involved. Freud recommended a neutral stance and

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trainee analysts were required to undergo analysis to work on complexes evoked by the patient's transference. Consequently, many analysts believed that the proper response to their countertransferential responses was to abolish them (Hinshelwood, 1994); abstinence and neutrality were the order of the day.

By the 1950s an alternative understanding of countertransference was developing, one which suggested that while countertransference feelings in the therapist were unavoidable and could be disturbing, they also yielded valuable information about the internal world of the client (Heimann, 1950; Little, 1951). These theorists argued that the therapist's understanding of the client's internal world was informed by projective identification, a defence first conceptualised by Klein (1946), whereby the client split off and projected disavowed affect into the therapist. According to Klein, projective identification was intrapsychic process and did not include the stimulation of affect in the therapist. Later Kleinians focused on projective identification as a communicative process; Bion (1957; 1961) in particular broadened the construct to include the feelings experienced by the therapist in response to the client's projections. Bion described a process of 'reverie' whereby the client projects part of their mind into the therapist who introjects and 'metabolises' it, before putting it back to the client in a form that can be reflected on, thereby demonstrating that disowned experiences can be tolerated, processed and understood (Gabbard & Ogden, 2009; Money-Kyrle, 1956). In doing so, the therapist contains the client's anxiety and modifies, detoxifies and transforms it for them, thereby making the 'unthinkable, thinkable' (Gabbard & Ogden, 2009).

Bion (1962) suggested that the provision of 'containment' allows the client to reintroject the experience which facilitates growth and development. In contrast, if the therapist becomes influenced by the projected feelings and lacks the capacity to tolerate them long enough to modify and detoxify them, they may then reject them (Bion, 1962). This resulted Bion (1962) suggested in an amplification of the projected material and a sense of 'nameless dread' in the client. Therefore, for containment to occur the therapist needed to be able to tolerate the 'emotional storm' long enough for it to be thought about and given meaning (Bion, 1962).

These theoretical and clinical developments have resulted in different constructions of countertransference, although these are often used interchangeably despite conceptual differences (Fauth, 2006; Hayes, 2004; Hayes, Nelson, & Fauth, 2015). However, there is a broad consensus within the field of psychoanalysis that countertransference is an inevitable and central part of psychotherapy (Burwell-Pender & Halinski, 2008; Coren, 2015; Gabbard, 2001; Gelso & Hayes, 2007; Hayes, 2004; Ivey, 2008; Ligiéro & Gelso, 2002; Marroda 2004; Pope, Greene, & Sonne, 2006; Rosenberger & Hayes, 2002). Furthermore, there is widespread agreement that while unmanaged countertransference can result in a negative therapeutic outcome and destructive enactments, countertransference which is contained, reflected on and managed, can benefit clinical work by illuminating both the client's and the therapist's interpersonal dynamics. It is suggested that the management of countertransferential material requires of the therapist the awareness and motivation to examine and work through countertransferential feelings as and when they arise (Burwell-Pender &

Halinski, 2008). However, this is not an easy task for the neophyte therapist who is faced with the task of processing and containing their clients' often intolerable affects, while also managing the various stressors and narcissistic injuries associated with training.

### *The therapist in training*

According to several authors (e.g. Hill, Sullivan Knox & Schlosser, 2007; Skolholt & Ronnestad, 2003; Theriault, Gazzola & Richardson, 2009) the developmental journey of therapists in training can be particularly difficult as they have yet to develop the necessary experience, self-awareness and reflective skills, which would enable them to manage the anxiety generated by the work, including their countertransferential responses. The literature suggests anxieties encountered when training can arise due to a number of factors, both internal and external.

It has been suggested that those attracted to the therapeutic professions may have unresolved narcissistic issues (Halewood & Tribe, 2003), and therefore may struggle when confronted with limitations and vulnerabilities, such as failing to meet an idealised professional self (Barnett, 2007). According to Barnett (2007), trainees often strive towards an idealised image of themselves as a way of defending against feelings of inadequacy caused by their narcissistic vulnerabilities (Barnett, 2007). Truell's (2001) qualitative study into the stressors inherent in counselling training found that participants felt that they should be able to solve all their client's problems and that they should be able to acquire counselling skills with ease and to perform them perfectly. Truell (2001) concluded that many trainees believed that they needed to have resolved their own personal conflicts to become a good therapist, as difficult feelings experienced in the work were attributed to themselves and therefore constructed as a sign of failure.

According to Kohut (1971, 1977) & Miller (1981), narcissistic vulnerability develops when the caregiver fails to mirror the 'normal' narcissistic needs of the infant, which impacts on the development of a cohesive self, leading to a fragile and fragmented ego. In addition, these individuals may struggle with the ambiguous and uncertain nature of therapy and the management of countertransferential material (Barnett, 2007; Mollon, 1986). Symington and Symington (1996) observe that the therapist's capacity to tolerate uncertainty will influence what they can bear and argues that this capacity is dependent on the demands of the superego. When the superego is unable to bear not knowing then it can become persecutory; not knowing can create anxiety in the trainee with a therapeutic ideal that they should always know what to do (Casement, 1985; Colman, 2006). This can be also be reinforced by the training experience, as trainees believe they need to conduct themselves in an overly competent manner to meet the expectations of the profession and avoid negative evaluation and criticism (Eckler-Hart, 1987). Therefore, when confronted with vulnerability and limitations, many trainees doubt their suitability for the profession, which they fear may be shared by teachers and supervisors (Eckler-Hart, 1987, Mollon, 1989).

This ideal can set up a 'vicious cycle' of anxiety and guilt, whereby the trainee not only feels ineffectual in the work with the client, but they also fear being found out or criticised by their supervisor or trainers (Barnett, 2007; Colman, 2006; Skovholt & Ronnestad, 2003; Yourman, 2003; Yourman & Farber, 1996). Supervision and training can therefore increase rather than decrease trainees' anxieties, until they come to understand that their countertransferential material is a normal and central aspect of the work (Burwell-Pender & Halinski, 2008; Marroda, 2012; Truell, 2001). Willingness to disclose countertransferential responses is also highly dependent on the supervisor's invitation to disclose, as well as their ability to normalise the trainee's experience (Ladany, Constantine, Miller, Erickson, & Muse-Burke, 2000; Southern, 2007). However, as Bridges (1998) notes, many supervisors don't have the skills or confidence necessary to help supervisees examine their own material, which can restrict supervisory discussions to an exploration of client data. The provision of containment would therefore seem to be important to enable the trainee to develop their own capacity to contain the client's anxieties (Price & Paley, 2008) and to practice non defensively.

Mollon (1989) suggests that many problems arise for trainees when transference and countertransference are not covered in the training curriculum, particularly in trainings where there is a focus on the client and not on the responses of the therapist. According to Fitzpatrick, Kovalak, and Weaver (2010), the teaching of psychodynamic theory can leave trainees feeling overwhelmed, scared, disconnected, bombarded and daunted.

This is supported by the research literature. Stefano, D'Iuso, Blake, Fitzpatrick, Drapeau and Chamodraka's (2007) qualitative study into trainees' experiences of therapeutic impasse, indicated that trainees tended to construct impasse as a failure; many trainees felt that there was a 'right' way to intervene which they had failed to grasp. Many of these participants reverted to basic listening skills in these cases – a method of coping which was ineffective in addressing the tension and conflict that they felt in the room. This suggests that participants became preoccupied with containing themselves, rather than focusing on how to tolerate or contain their clients' projections.

Given the stressors and anxieties encountered when training to be a therapist, it seems pertinent to explore the contexts within which trainee therapists are working, and their role in containing the anxieties that trainee therapists experience. Furthermore, it seems important to identify the processes that enable therapists in training to develop awareness and understanding of their countertransference and to offer a containing environment to their clients.

## The present study

The study adopted a qualitative methodology; this is suggested to be particularly suited to the study of psychotherapy processes (Hansen, 2004); as it enables the gathering of data that is rich and illustrates the phenomenon of interest intensely (Polkinghorne, 2005). The current paper is taken from a doctoral study (Gait, 2017).

## *Methodology*

### *Sampling and participants*

Initially a purposeful sampling strategy was employed to identify eight therapists who met the inclusion criteria of (a) a recognised qualification in a school of therapy, e.g. counselling psychology, counselling, psychotherapy; (b) at least 1 year clinical experience of working one-to-one with clients, (c) some awareness of the construct of countertransference, to enable them to reflect on how, if at all, it had influenced the therapeutic relationship with their clients. There were no explicit exclusion criteria.

In accordance with the grounded theory method as the analysis developed a theoretical sampling strategy was adopted in order to refine categories, with a further seven therapists recruited, two of whom had qualified in the last year to capture the development of countertransference awareness over time, two who were not working with countertransference awareness explicitly to further develop the theoretical pathways under construction and three who were also practicing supervisors to further explore the role of supervision on the development of countertransference awareness. See Table 1 for participant demographics.

### *Procedure and analysis*

Following ethical approval from the University of the West of England Research & Governance board, information regarding the study was posted on a number

Table 1. Participant's demographics.

| Participant | Gender | Occupation/therapeutic approach |
|---|---|---|
| P1 | Female | Psychologist/private practice |
| P2 | Female | Psychological Therapist IAPT/trainee counseling psychologist |
| P3 | Female | Psychotherapist/CAMHS |
| P4 | Female | Psychotherapist – Humanistic & Integrative/Private Practice |
| P5 | Female | Psychodynamic Psychotherapist – Psychoanalytic/University counseling service |
| P6 | Female | CBT therapist/trainee counseling psychologist |
| P7 | Male | Integrative Counsellor/trainee counseling psychologist |
| P8 | Female | Counsellor & Psychotherapist – psychodynamic/University counseling service |
| P9 | Female | Integrative psychotherapist/trainee counseling psychologist/private practice |
| P10 | Female | Integrative counsellor/private practice |
| P11 | Male | Psychotherapist/Supervisor/private practice |
| P12 | Female | Psychotherapist/Supervisor/Mental Health service/private practice |
| P13 | Female | Psychological Therapist IAPT/integrative counsellor/private practice |
| P14 | Female | Counselling Psychologist & Supervisor/private practice |
| P15 | Male | CBT Psychological Therapist IAPT |

of sites pertinent to therapists: The British Psychological Society (BPS) Division of Counselling Psychology (DCOP) website and Counselling Psychology and Counselling & Psychotherapy sites on Facebook, JISCMAIL a free online email database and LinkedIn, a professional networking site.

Fifteen semi-structured interviews were conducted; eight were face to face and four were conducted online via Skype. Participants were asked about the development of countertransference awareness and whether it had influenced the therapeutic relationship. Participants were asked for two client examples to illustrate their development before and after they had developed their countertransference awareness. Each individual interview was audio recorded and lasted up to one hour. Interviews were then transcribed in full and analysed using a Constructivist Grounded Theory methodology (Charmaz, 2006, 2008, 2011), which involved multiple stages of analysis. Initially, each line of data was open coded to capture the actions and processes. These open codes were then used to sift through larger segments of data, leading to the development of more nuanced, abstract focused codes. The analysis of the transcripts took place concurrently with interviewing, each process informing the other. Memos and diagrams were used to capture ideas, theoretical links, relationships, differences within and responses to the data and the codes throughout the analysis and to develop theoretical categories.

Theoretical sufficiency (Dey, 1999) was considered to have been reached when the pre-existing categories were sufficient to capture the new data obtained through further sampling and analysis. The study used Charmaz's (2006) method for evaluating a grounded theory study to ensure the analysis remained grounded in the data. As part of this validity checking process, the diagram of the research process was sent out to five participants who took part in the study, who confirmed the diagram had captured their experience.

### *Reflexivity*

The first author and principal investigator is a relational Counselling Psychologist with an interest in countertransference and the two-way, intersubjective nature of the therapeutic endeavour. A research journal was kept throughout the research process as this is understood as an effective strategy to facilitate reflexivity to capture personal assumptions, biases and goals, making them more available for reflection and scrutiny (Etherington, 2004, 2001).

## Findings

The grounded theory constructed from the data describes the role containment played in the development of countertransference awareness for therapists in training. Early in their training participants described experiencing a number of threats to their personal and professional sense of self, leading to high levels of anxiety. As participants progressed through their training, the absence of a containing other or framework to help them to think about and understand what was being evoked in

them by their clinical work led many to follow a defensive pathway; the focus here was less on understanding countertransferential responses and more on managing what were sometimes overwhelming levels of anxiety through the adoption of defensive strategies. However, this lack of awareness, and for many a lack of containment, led some participants to act out their countertransferential responses in the therapeutic relationship, as their anxieties became 'amplified'. Conversely, if these anxieties were contained, participants' anxieties were detoxified and they were able to develop their own reflective capabilities and therefore their countertransference awareness. This enabled participants to move away from feelings of incompetence as they began to develop a framework which helped them to develop and make sense of their countertransferential feelings and responses. Over time a small number of participants began to reflect in the moment; some appeared to have internalised containing others who supported their developing countertransference and self-awareness. This enabled participants to engage more fully in the therapeutic relationship.

Movement between the two pathways seemed to occur primarily when there was a change in containment or when participants re-experienced threats to self.

### *Experiencing a threat to self*

Participants described the threats to both to their personal and professional sense of self during training which led to high levels of anxiety. For many participants, the reality of client work was somewhat different to their expectations; participants described feeling overwhelmed, both by what was evoked in them by their client work, and by their struggles to understand both theory and practice. A further threat was experienced by the process of engaging in a high level of self-scrutiny which left many participants feeling inadequate and incompetent. Participants also feared the scrutiny of others believing that this would expose their vulnerabilities and confirm that they were unsuited to be a therapist. The category *Experiencing a threat to self*, compromises the subcategories, *being overwhelmed by countertransference response, struggling to understand theory and practice*, and *judging self and fearing judgement.*

#### *Being overwhelmed by countertransferential response*

Participants described feeling unprepared for the emotional responses that the client material and the client could evoke in them. Lacking either a theoretical or an experiential understanding of countertransference at the outset of their training, participants were understandably ill-equipped to cope with remaining present and responsive to their clients, while regulating and reflecting on their own responses in the therapeutic relationship. In the absence of a framework for processing these experiences, participants were left feeling emotionally overwhelmed, as illustrated by the following quotes:

*'He had this enormous sense of power about what he was saying and I felt very frightened at the time'* Participant 1

*'It was quite scary I remember her being quite … … not her being but the work being quite scary in terms of it being my first sort of experience'* Participant 3

Feelings of confusion, uncertainty and doubt added to the sense of overwhelm:

*'Because of certain similarities in our background it was, she was very, it was incredibly difficult for me to ascertain, and I had her quite early on in my experience, um ascertain what exactly was going on in the room'* Participant 10

*'I got into quite a tangle at the time because when I was younger I was scared of anger … I got confused with my fear of her anger. So again, the spotlight was on me, oh dear it's my problem with anger'* Participant 8

### *Struggling to understand theory and practice*

Being introduced to the theoretical construct of countertransference in advance of working with clients was similarly problematic as it was a difficult concept to understand without experience. This led to further anxieties and self-criticism:

*'I remember feeling quite stupid because it's so fundamental to the work and I don't understand it'*Participant 9

*'When you first train and you kind of get in a room with a client and you know your there with your theories and you know when you first start out basically it can be really difficult until you get enough clinical experience to sort of understand situation'* Participant 3

### *Judging self & fearing judgement*

Lacking either a theoretical or experiential understanding of countertransference at the outset of their training, participants struggled to make sense of their responses to their clients, which were instead constructed as an indication of incompetence:

*'I felt pulled to him and I felt really bad, I thought I'm being really unprofessional, you know having some kind of feelings for someone'* Participant 2

When participants' feelings and responses didn't fit with their therapeutic ideal they became self-critical and feared that their personal failings and incompetencies would be exposed resulting in them being judged as unsuited to the profession:

*'I didn't want to look weak, I didn't want to look like the therapist in training, who hadn't sorted her own stuff'* Participant 9

As participants progressed through their training they began to follow a reflective or a defensive pathway; the adoption of a particular pathway appeared to be influenced by the level of containment provided to the trainee, as well as by the development of self-awareness, experience and level of defensiveness.

### *The reflective pathway*

#### *Experiencing containment*

Participants who experienced containment were able to process their experiences; and this was instrumental in the move away from defending against internal and external threats and developing countertransference awareness through the process of reflection. A critical component of a containing framework was that it offered participants a space and time to reflect and think about their countertransferential responses. Supervision, the training and organisational contexts, trainee's theoretical framework and personal therapy were all identified as performing a containing function.

#### *In supervision*

The supervisor's response to the sharing of clinical material seemed to be a critical; this enabled participants to experience supervision as a supportive, safe and trusting space; one where they didn't fear judgment as their experiences were normalised and understood:

> *'I was really embarrassed to take it there … by actually talking about it and kind of understanding what was going on.I could., I could see it in a different way. I didn't feel embarrassed as I understood it'* Participant 2

This seemed to foster a strong alliance enabling the more difficult aspects of the work to be shared and considered which helped participants to move away from feeling shamed, incompetent and defensive Furthermore, the supervisor's response seemed to stimulate participant's interest in, and curiosity about, their countertransferential material, enabling them to develop both their emotional and intellectual awareness:

> *'this sense that not only that I should take everything but I can.at the same time it's a feeling on my part I want to know'* Participant 10

#### *Training contexts*

Countertransference development was also supported by training contexts, which privileged an attendance to countertransference by offering both a guiding framework and opportunities for reflection on countertransferential responses:

*'I would say. by virtue of my training countertransference has become one of the key aspects of my practice'* Participant 5

*'I have got the breadth of theory that gives you the sense making explanation and the vocabulary to actually be able to describe what I am experiencing'* Participant 10

### *Organisational contexts*

Some participants worked in contexts where attendance to countertransferential material was part of the organisational culture, and where there was an expectation and requirement to participate in reflective practice:

*'We have once a week clinical meeting as a way to think about client, um try to see what comes up from, you know different people and we think we are picking up different things'* Participant 5

*'I think because I work with a bunch of therapists as well were always kind of discussing those kinds of things'*. Participant 3

### *Personal therapy*

For some participants their personal therapy offered a space for reflection, enabling them to recognise and separate out their own dynamics and material from that of their clients:

*'to have the therapeutic work on yourself so you know what your own material is and then you can join up the dots'* Participant 4

*'I don't really think the training course covered CT enough and I became aware of it more in my personal therapy'* Participant 7

Containment in these domains appeared to increase participants' capacity to offer containment to their clients. Participants became more able to tolerate their clients' projections enabling them to be more available to their clients and to engage in reverie – thinking about the clients experience rather than trying to discharge it.

### *Tolerating vulnerability*

By becoming more able to tolerate their own discomfort and vulnerability in supervision, therapy and in session, participants became increasingly able to tolerate their clients' projections and to make sense of them:

*'When is out of awareness I don't feel, I don't like this, it's just uncomfortable so you know there is something to be said for sitting with the discomfort but also really trying to unravel it'*. Participant 10

*Being with but staying separate*

Participants began to interpret their countertransferential responses in a way that helped them to remain therapeutically involved with the client, whilst also remaining sufficiently separate to think about the experience:

> *'I think you have to be caught up in it, sometimes to understand it, you have to be in the experience, if you're not going to allow yourself to be caught up in it, you won't understand something'* Participant 12

This ability increased participant's capacity to pay attention to, and think about, their experience in the room with their clients. Developing levels of self-awareness facilitated participants' insight, which increasingly enabled participants to differentiate between their own dynamics and those of their clients, thereby facilitating the provision of a containing environment.

## *Discussion of the findings*

The findings indicate that developing awareness of countertransference is not an easy task for a therapist in training, who can feel unprepared for the challenges and realities of the work. As a result, they can struggle to remain present in the therapeutic relationship, as they became caught up in containing their own powerful affect. The existing research and theoretical literature indicates that feeling overwhelmed as a trainee therapist is not unique to the participants in this study, with many trainees reporting they felt ill-equipped to respond to another's distress, and that they frequently felt distracted and overwhelmed by their internal affective states (Cartwright, Rhodes, King, & Shires, 2014; Cohen & Hatcher, 2008; Hill, Sullivan Knox & Schlosser 2007; Nutt-Williams & Hill, 1996; Theriault 2009; Truell, 2001). When this resulted in defensive disengagement from the client, trainees constructed this as an indication of incompetence and doubted their therapeutic abilities.

Participants in the present study were able to move away from a need to defend the self when they were offered sufficient containment in a number of contexts. This offers a conceptual framework for understanding how participants in the present study faced, understood and effectively thought about their countertransference, rather than defensively discharging it. According to Bion (1961) for reflective practice to be possible, 'containers' need to be provided, which offer the appropriate physical, mental and emotional space required to engage in reflection. The findings of the current study indicate that containing contexts plays a central role in the development of reflective practice and the ability to contain and think about the work for therapists in training. Furthermore, the findings add empirical support to Bion's container/contained model, in particular how training initially amplified trainees' anxieties, and how these became detoxified through the experience of a 'containing other', i.e. the supervisor, training environment, theoretical framework and personal therapist. This enabled the experience to be thought about, which then enabled the participant to tolerate the experience and use it to the benefit of their clinical work.

Within the counselling and psychotherapy literature, it is suggested supervision is often where therapists first begin to develop their countertransference awareness (Pakdaman, Shafranske, & Falender, 2015), a suggestion that is supported by the findings of the present study. Pope et al. (2006) highlights that a sense of safety and basic trust in the integrity of supervision is essential as to explore topics, which may feel 'taboo', or threatening in some way, involves taking a risk on the part of the supervisee. They suggest that the notion of safety comes from the knowledge that what is shared will not be a threat to the personal and professional self (Pope et al., 2006). The findings add support to the need for a containing supervisor for a therapist in training, as it is initially the supervisors mind which performs this function for the trainee, transforming threatening material into a meaningful experience which can be tolerated, understood and integrated. In contrast without a containing supervisor, participants were unable to reflect and consider their countertransferential material, which resulted in defensive strategies and unwittingly acting out their countertransference in the therapeutic relationship.

Countertransference awareness was also identified by participants' as developing in personal therapy as this offered a space for the exploration of material evoked by the work, which often seemed to lead participants to reintegrate previously disowned parts of the self. There is some support in the wider literature on the benefits of personal therapy in developing self-awareness. According to Kumari (2011) personal therapy can help therapists gain more insight into interpersonal dynamics by increasing self-awareness in the therapeutic relationship. Kumari suggests that personal therapy can aid therapist in separating out their own issues from those of the clients and in doing so, reduces the possibility of countertransference reactions. There is some debate in the literature on whether personal therapy should actually be mandatory for therapists in training as according to some authors there is no proven benefit to therapists engaging in personal therapy and client outcomes (Clarke 1986, Macran & Shapiro, 1998).

The findings of the present study seek to challenge this assertion; participants in the present study used their personal therapy to develop awareness of their own dynamics, which led to personal and professional development, with participants more able to identify their countertransference when it arose in the work. Given that personal therapy can develop therapist awareness and insight into their own dynamics, these findings would seem to suggest that it is beneficial to client outcomes if it enables therapists to manage their countertransference behaviours rather than acting out unwittingly within the therapeutic relationship. Perhaps the disparity in findings suggests that for therapy to be effective, it needs to be experienced as containing.

It is also important to note that participants were from different training backgrounds, therefore, the understanding and motivation to develop countertransference awareness varied; participants on psychoanalytically informed trainings were more familiar with the construct and were expected to engage in personal therapy to a greater degree than participants training in CBT.

### *Implication of the findings*

The grounded theory outlined above indicates the importance of containment in developing reflective practice, countertransference awareness and personal development in trainee therapists. The findings suggest that unless trainees have a way of conceptualising their responses to clinical material they are left experiencing a great deal of anxiety regarding their own competence in addition to containing their clients' anxieties. Therefore, ensuring trainees are offered some teaching on countertransference would seem of great importance to the development and containment of trainees while training. The findings illustrate the struggles faced by therapists in environments where there is a failure of containment. Given that therapists are increasingly working in mental health-care systems which privilege targets and outcomes (Rizq, 2009), this clearly presents a challenge; how to maintain reflective practice and attention to the therapeutic relationship, while working in services with differing priorities.

While the training context may serve as a place for trainees to begin to learn about countertransference theoretically, the findings seem to suggest that it is the clinical supervisor who may be in the best position to support the integration of theoretical and experiential learning. According to Ponton and Sauerheber (2014), supervisors are essential in the transition from theory to practice, and in supporting trainees to use themselves in the therapeutic relationship. For supervision to be effective in these circumstances the supervisor needs to be able to facilitate a culture of trust where the trainee can begin to develop their awareness. Helping neophyte therapists to manage their countertransference through supervision requires supervisors themselves to have a theoretical knowledge and understanding of the construct of countertransference or a comparative framework, which focuses on the therapist's feelings and responses as much as the clients. Without a framework, supervisor's risks facilitating a culture where the more challenging aspects of the work are not disclosed.

### *Limitations and recommendations for future research*

Participants who took part in the study did so because they had an interest in the topic, which may also have impacted the findings as they may have offered what they considered to be, socially acceptable or desirable responses. Furthermore, participant's transferential responses to the researcher and the researcher's countertransferential responses to the participants may have influenced what participants felt able to disclose.

The decision to use Skype as a method of interviewing was based on the assertion that Skype affords both the researcher and the researched many benefits, for example, access to a larger geographical area, flexibility and reduced research costs (Hamilton & Bowers, 2006; Hanna, 2012; James & Busher, 2009; Sullivan, 2012). However, using Skype may have also limited the findings as the technology broke down on several occasions during a few of the interviews, which disrupted the interview, and may have impacted on the development of rapport. Currently

there is some debate amongst researchers and authors on the development of rapport via a Skype interview, with some researchers and authors (Hanna, 2012; Seitz, 2016) arguing that Skype can increase the development of rapport, remaining in their own environments is thought to facilitate participants' safety and comfort thereby leading to greater openness. This claim has been challenged by some researchers and authors (Seitz, 2016; Sullivan, 2012), who have suggested that technical glitches break the flow of the narrative, creating a level of stress and distraction and inhibiting rapport. With the present study, it is hard to ascertain how much technical difficulties impacted the data or whether or not participants would have made the same disclosures in a face to face interview. Therefore, it is difficult to draw any real conclusions on whether online interviewing increases disclosure due to its perceived anonymity, suggesting more research is needed in this area.

It would be fruitful to build on the findings of the present study to investigate how countertransference is taught in different schools of therapy and how this relates to awareness and management of it. It would also be useful to explore how different therapists engage in developmental work and reflection and whether there are difficulties and/or limitations in practice of assimilating the construct of countertransference into different theoretical perspectives.

The findings therefore offer a useful conceptual framework for understanding the training experience, as they highlight that to provide containment and develop countertransference awareness, trainee therapists need to experience containment for themselves. It is the introjection of this experience that appears to enable the trainee therapist to offer this experience to another. The framework also indicates how the absence of a containing other can result in trainees following a defensive pathway, to the detriment of their own development and the therapeutic relationship.

## Disclosure statement

No potential conflict of interest was reported by the authors.

## Notes on contributors

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