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ABSTRACT

The literature extensively examines the clinical constructs of countertransference and premature termination through several theoretical orientations. It explores how countertransference is one of the most significant variables in successful therapy outcomes, and how premature termination is often an outcome of a poor therapeutic alliance stemming from the client's insecure attachment to primary caregivers (Berg & Lundh, 2022; Westerling et al., 2019). However, few studies explore the interconnection of these two constructs and how clinicians process their countertransference when it interferes with their ability to provide effective treatment. Despite the gap in the literature, clinicians are bound to experience countertransference in their work with clients; thus, the literature must provide language to describe these experiences to lessen the feelings of guilt, shame, and uncertainty that tend to emerge through these processes. This clinical note aims to provide a review of these constructs through a case study to emphasize the clinical, ethical, and legal dilemmas clinicians encounter when they experience countertransference throughout the course of therapy. While experiences of countertransference are intimate and painful for the clinician, they are bound to happen; and it is the responsibility of the clinician to address them in the best interest of the client.

Introduction

Social work literature extensively examines the notions of countertransference and therapeutic impasses through various theoretical orientations. The challenges of termination are also discussed (Prasko et al., 2022); however, few studies explore the clinician's countertransference and subsequent decision to initiate an untimely termination. The ethical dilemma of initiating termination becomes increasingly complex when considering the client's presenting problem, attachment style, and the nature of the therapeutic relationship (Dalenberg, 2005). This dilemma may be exacerbated by the clinician's conflicting feelings and concerns about

unintentionally hurting or abandoning their client (Prasko et al., 2022). Weddington and Cavenar (1979) refer to this as the "countertransference storm," since many clinicians feel insecure and flooded with feelings of guilt, shame, and self-doubt. Yet, when a client's narrative triggers acute discomfort in the clinician, it is simply a sign that the clinician needs to be aware of the thoughts and feelings that are being elicited within them. These countertransferential responses can then be used as a tool to deepen the therapeutic process.

Everyone carries the weight of their past relationships and experiences. Countertransference is not an indication of incompetence, rather it is a subjective experience that informs clinicians of their individual and shared experiences in the room (Dalenberg, 2005; Westerling et al., 2019). Just like the signs on the highway are indicative of what the speed limit is and intend to provide direction in consideration of fellow drivers and safety laws, countertransference is a routine aspect of being a clinician and is a primary tool of clinical work. Experiences of intense affect in the room provide valuable insight for the clinician, oftentimes redirecting the work into deeper territory where profound healing can take place.

Countertransference

As the field of psychotherapy evolves, so does the understanding of countertransference. Based on the work of Freud and other leading analysts, countertransference was defined as a clinician's response to their client's transference (Abargil & Tishby, 2021). Freud developed this term in 1910, and from his classical vantage point, countertransference was to be avoided at all costs lest it interfere with the work. Freud first alluded to this term in a letter to Carl Jung in regard to a love relationship he had with a patient (McGuire, 1979). Unlike Freud who believed this would be an obstacle to Jung's treatment with his patient, Jung viewed this emotional reaction as the heart of his method and invited these countertransferential feelings to guide his work (Jung, 1944; McGuire, 1979). Although they did not openly discuss their opposing views, a year later Freud coined the term countertransference and explained, "We have become aware of the 'countertransference', which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this countertransference in himself and overcome it" (Freud, 1910, pp. 144–145). While Melanie Klein and others concurred with Freud's interpretation of countertransference as being an obstacle to the work, succeeding theorists began to conceptualize this construct from a broader perspective (Stefana et al., 2021).

In the 1950s, the psychoanalytical interpretation of countertransference reached a new dimension. Theodore Reik was one of the leading theorists

to suggest a different perspective with the publication of his book, *Listening with a Third Ear.* In his work, he suggests clinicians must use their unconscious to guide intervention. Several psychoanalytical theorists followed in his footsteps and concurred with the belief that clinicians need to sustain and work with their affect, not hide, or try to eradicate it. In an article on countertransference, Paula Heimann (1949) writes, "My thesis is that the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious" (p. 81). Her work, along with other leading psychoanalytical theorists, suggests that countertransference includes all emotional reactions to a client and is an opening for deeper work. As Racker (1957) explained, "Countertransference is the entirety of images, feelings, and impulses towards the patient—an important tool for analytic practice" (p. 323). He held that unprocessed countertransference could distort the clinician's interpretations and behaviors toward their client, and in turn influence the client's transference. This perspective lends insight into the work of Winnicott (1949) who defined countertransference as a portion of the client's transference and labeled it as *objective countertransference*. To summarize, this means that the therapist's unprocessed pathology might interfere with his ability to respond therapeutically, inadvertently eliciting a transferential response within the client. Of course, the response elicited will be specific to the client's pathology and unconscious conflicts, and thus Thomas Ogden (1979) built on this construct to develop the term *projective identification*. He explains this as the clinician's participation in the emotional journey of the client but argues that it is stemming from the client's transference as opposed to the clinician's countertransference (Ogden, 1979; Weiss, 2014). Undoubtedly, these conceptualizations of countertransference greatly differ from Freud in the belief that it is not merely an obstacle to treatment but can simultaneously be the most instrumental tool and greatest danger to treatment (Stefana et al., 2021).

Researchers continued to study this construct and wondered whether these unrecognized or unexplored emotional reactions could provide clues about ruptures in the therapeutic alliance (Aleksandrowicz & Aleksandrowicz, 2016; Berg & Lundh, 2022; Hayes, 2004). With time, psychoanalytic theorists began to understand that countertransference is not merely a clinician's reaction to a patient, nor does the response belong solely to the clinician; rather it is an outcome of a relational experience between the clinician and client (Abargil & Tishby, 2021). In the late 1990s, Gelso and Hayes aligned with this perspective by explaining that countertransference is simply a tool to enhance the work of psychotherapy (Marin, 2019). They further defined countertransference as "The therapist's responsibility in the intersubjective experience of psychotherapy" (Marin, 2019, p. 182).

This conceptualization strengthens the notion that countertransference is not a sign of incompetence or an obstacle to the process but rather a means by which clinicians can deepen their work with clients. This theoretical perspective differs greatly from Freud and other theorists who suggest countertransference is an obstacle to the work. The assumption is that when it is not used as a tool to guide treatment, countertransference could lead to ruptures in the therapeutic alliance. In light of the differing opinions, it is important to clarify that the authors hold the theoretical perspective and carry the assumption that countertransference is the heart of the method of treatment and one of the leading variables in successful therapy outcomes (Westerling et al., 2019).

Countertransference exists on varying levels of consciousness within the clinician. Whether spoken about or not, these experiences exert a powerful influence on the therapeutic relationship and course of treatment (Foster, 1998). Clinicians will use different coping strategies and defense mechanisms to manage their discomfort, and most often, clients will recognize these reactions, even if only viscerally. Unmanaged countertransferential reactions will often cause a clinician to become less attuned to their client's needs and consequently lead to ruptures in the therapeutic alliance (Penn, 1990; Tishby & Wiseman, 2022). This can be detrimental to the therapeutic alliance and course of treatment; however, when processed and used skillfully, strong, and intense emotional reactions within the clinician can be highly valuable to the work (Penn, 1990). It increases empathy, compassion, and creates an opening for the clinician to connect more authentically with their client.

Recent research focuses on the interconnection between countertransference and the attachment of the clinician and client (Barreto & Matos, 2022). The ways in which clinicians respond to their clients maintain therapeutic and diagnostic value as these responses provide information about both their internal working models (Westerling et al., 2019). The concept of an *internal working model* was developed by John Bowlby (1988) in his effort to theorize attachment and explain how humans develop relational schemas. According to Bowlby, the internal working model is a primary adaptive structure that provides children with the ability to develop relationships with significant others. These relational schemas are reenacted in the helping relationship, and thus therapeutic interactions will provide insight into the clinician's vulnerabilities and the client's relational struggles (Bowlby, 1988; Obegi & Berant, 2010). The research shows a clinician's countertransference will manifest itself in the room as "over-engaged" or "disengaged" (Berg & Lundh, 2022). This is often seen in the clinician who over-identifies with the client, resulting in over-engagement, or the clinician who under-identifies with their client, resulting in higher levels of disengagement (Berg & Lundh, 2022). These responses are based on

the attachment styles of both parties, and the one that is more likely to emerge in the room based on the unique relational dynamic of the clinician and client. For instance, clients with avoidant attachment tend to engage with less reactivity while those with anxious attachment respond with hyperactivation and a greater need for close proximity with the clinician (Westerling et al., 2019). Clinicians will then respond to these attachment needs based on their own primary attachment style, further emphasizing their vulnerabilities and internal working models (Barreto & Matos, 2022). Again, these countertransference responses serve as information to enhance the therapy process and need to be acknowledged and processed by the clinician.

Termination

Similar to the construct of countertransference, the concept of termination was originally introduced by Freud as well. Although the term *termination* seems to connote a harsh indication of the ending of psychotherapy, Freud chose this term with the intention of conveying that therapy is a limited experience and clients will continue to endure adverse life events and emotional challenges beyond the therapeutic encounter (Schachter et al., 2018). As he stated, "Our aim will not be to demand that the person who has been "thoroughly analyzed" shall feel no passions or develop no internal conflicts" (Freud, 1937, p. 250). He further explains that clinicians will not always fully meet their goals through their course of work with a client. He supports this theoretical perspective based on his belief that unless a conflict is present, it is unavailable for analytic interpretation or interruption (Freud, 1937).

Termination remains a multi-faceted construct of therapy and theorists continue to grapple with its complexity as they study it both from the perspective of the clinician and client. The recent work of theorists explains that the process of termination often triggers earlier attachment wounds, histories of painful losses, and underlying pathologies (Barreto & Matos, 2022; Berg & Lundh, 2022; Schachter et al., 2018; Tishby & Wiseman, 2022). As seen in the literature, many of these are shared experiences of the clinician and client. While clients might struggle with accessing these experiences, clinicians cannot ignore or deny their emotional reactions but need to affirm their humanity in the therapy room. By doing so, they will strengthen the alliance, model healthy relational interactions, and enrich the termination process for the client.

Clinicians tend to experience increased positive feelings of pride and satisfaction when termination is timely, and display more intense reactions of loss, shame, and incompetence when it is abrupt, untimely, and premature (Alfonsson et al., 2023; Fragkiadaki & Strauss, 2012; Lee et al.,

2023). Generally, there are four main types of termination: client-induced, clinician-induced, mutual, and forced (Lee et al., 2023). While this manuscript briefly examines these different forms of termination, the focus of this study is to shed light onto the intricacies of premature termination, which is also referred to as "forced termination" by multiple authors.

Premature termination

There is minimal research on the termination phase of psychotherapy, let alone the intricate process of premature termination (Kramer, 1986). While clinicians lean on multiple theoretical constructs to navigate the ending phase of treatment, these practices are often inept when it comes to premature terminations. The term *premature termination* is loosely defined as the untimely completion of therapy that defies an opportunity for resolution (Frayn, 1992). While there are several conditions that predict premature termination, the research mainly focuses on therapeutic impasses, alliance ruptures, and the client's level of social, emotional, and intellectual functioning (Frayn, 1992). The research further emphasizes that most incidents of premature termination are a result of the client's lack of compliance, poor functioning, or inability to engage in treatment (Frayn, 1992; Kramer, 1986; Siebold, 1992). The studies show the majority of clients who end therapy prematurely struggle with a low tolerance for uncertainty, high levels of dysregulation, and insecure attachments with primary caregivers (Piselli et al., 2011). This occurs because the process of individuation and separation is enacted within the therapeutic relationship as well (Siebold, 1992). When these reenactments are addressed skillfully by the clinician, they create an opening for healing. However, when they are overlooked or undermined, the rupture itself becomes the reason for an untimely termination as the client is not able to integrate their transferential reaction in a healthy way.

Most of the literature holds the client responsible for the premature termination; however recently, researchers began to examine the clinician's role in unsuccessful treatment outcomes (Alfonsson et al., 2023; Levitt et al., 2016). Alfonsson et al. (2023) conducted a qualitative study on the mediating variables of premature termination from a client's perspective. Their study highlighted many critical components, including the importance of relational skills, theoretical and cultural competence, personality traits, and levels of engagement. Of course, serious breaches of boundaries, confidentiality, or lack of competence would necessitate termination on behalf of the client, but such circumstances significantly differ from those where ethics, values, and professionalism were practiced. Thus, these conclusions compel us to ask the question of, "If all is going well, what drives a client to terminate prematurely?" Clinicians will rely on multiple

theoretical constructs to understand these processes, but from the client's point of view it is often a result of disengagement, lack of progress, deterioration of symptoms, loss of confidence and hope in recovery, unresolved therapeutic ruptures, financial, or interpersonal struggles (Barlow, 2010; Bowie et al., 2016; Levitt et al., 2016). This question lends itself to yet another one, "What could clinicians do differently to avoid negative treatment outcomes and premature terminations?" While many clinicians rely on attachment theory to understand these alliance ruptures and treatment failures, this phenomenon also needs to be examined from the client's perspective to enhance practice procedures. This assumption is examined more fully in the work of Judy Kantrowitz (2014) where she explains the significance of *listening* to our patients for guidance in understanding their relational needs.

Premature termination is often referred to as a painful process; however, every so often it is a neutral agreement between the clinician and client (Siebold, 1992). That is, both clinician and client agree termination is the most plausible course of action and the surrounding affect is neither intensely positive nor negative. While some clients abruptly terminate treatment, others discuss their dissatisfaction and concerns with their clinicians, allowing for a more positive outcome. Other times, the clinician's keen awareness guides them to end the relationship in a safe and holding manner (Kramer, 1986). The latter, though engendered by the clinician in a reflective way, could still result in clinical, ethical, or legal consequences.

While clients play a role in their decision to terminate prematurely from treatment, the countertransference of clinicians also influences the ending of a therapeutic relationship. Clinicians experience countertransference at varying levels of consciousness which tend to be aroused in response to family of origin, social, cultural, or earlier traumatic experiences (Foster, 1998). These countertransferential reactions stimulate a flow of information between the clinician and client and allow for the clinician to tap into the client's adverse childhood experiences that may have preceded verbal and linguistic development. Studies show that clinicians working with trauma survivors have stronger somatic and emotional reactions to their clients' experiences, and therefore need to take intentional steps to address these responses in supervision and personal therapy (Cohen & Collens, 2013; Marin, 2019). This presents as being attuned to one's somatic and emotional responses in session, being open and curious to explore these reactions in supervision and personal therapy, and taking responsibility for how these issues might surface in the therapy room (Marin, 2019). Oftentimes, clinicians dissociate certain painful experiences to the extent in which they remain unconscious; however, the client might still notice and respond to it. It is therefore also the clinician's

responsibility to practice observing his/her emotional, somatic, and cognitive experiences to increase self- awareness and their capacity for introspection (Marin, 2019). The reality is ruptures in the therapeutic alliance and premature terminations are more likely to occur when clinicians avoid, deny, or minimize their countertransference; thus, it is imperative that clinicians prioritize this element of the therapeutic journey and affirm their humanity in the room (Cohen & Collens, 2013; Marin, 2019; Piselli et al., 2011). Of course, this is best attained through the work of ongoing supervision and personal therapy.

The scarcity of literature about the connection between countertransference and premature termination reveals its significance and of the feelings of shame, ambivalence, and guilt it elicits within the clinician (Siebold, 1992). Clinicians hold the position of healer, and thus it is incredibly painful when termination occurs in response to their trauma being triggered by the person who came to be healed (Marin, 2019). Piselli et al. (2011) explain that the premature termination of a client is so significant that it often impacts the clinician's relationship with current and future clients as well as their personal well-being. While self-reflection is a core attribute of clinicians, it is important to outwardly speak of these experiences to lessen the self-imposed shame and guilt that clinicians carry in such incidents.

Unresolved countertransference experiences could lead to incidents of premature termination, yet oftentimes clinicians choose to terminate treatment in response to working through their countertransference in supervision or personal therapy. This might be because of earlier or current experiences that hinder their ability to treat this particular client, including but not limited to cultural differences, adverse childhood events, intrapersonal conflicts, or personal or professional limitations. For example, a clinician might be unable to treat an eating disorder because they lack training in that area or because they previously or currently struggle with a similar issue and are aware of their limitations. Despite the judgment often imposed on clinicians who initiate termination, the reality is that these clinicians are displaying high levels of competency as they are aware of their own histories, attachment styles, needs, and limitations. Too often clinicians hold back from initiating termination in fear of appearing incompetent, unskilled, unempathetic, or lacking in ethics, morals, and values. While continuing to work with their clients might seem virtuous, if their struggles are ongoing or remain unresolved, then it will only result in a therapeutic impasse where the client will be forced to initiate the premature termination after being stuck in this position for an excruciatingly long period of time (McClure & Hodge, 1987; Perlstein, 1998). Needless to say, it is imperative that the clinician keeps the client's best interest in mind while holding the

knowledge that premature termination is sometimes the most clinically and ethically appropriate call of action.

Ethics

The NASW *Code of Ethics* intends to provide a practice framework for clinicians for professional development and guidance in resolving and preventing ethical dilemmas. The six core principles of the *Code* include service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 2021). These core principles incorporate multiple ethical standards that are relevant to professional practice, including the *termination of services*. Under this section, the *Code* states that social workers should terminate services when they are no longer needed or beneficial to the client (NASW, 2021). It further explains specific conditions that might lead to premature termination, like financial difficulties or changes in employment, as well as those that should not determine the termination of services, like the desire to pursue social, financial, or sexual relationships (NASW, 2021). Of necessity, these standards remain somewhat ambiguous as they intend to provide a structure for care. Since they are not precise directions for care, clinicians are often conflicted when considering untimely terminations.

The *Code* describes ethical dilemmas as a "circumstance in which two or more ethical principles of social work conflict" (NASW, 2021, p. 1). Abramson (1985) explains that these dilemmas arise when "social workers are not sure about what is right or what is good or when there is a conflict between opposing moral systems or obligations" (p. 387). It is under these circumstances where clinicians need to consider their prima facie duties to ascertain how to resolve their ethical dilemmas. This includes careful reflection on the moral principles of autonomy, beneficence, non-maleficence, and justice. The struggle, as described by Reamer (1982), is that clinicians need to consider between two "independently acceptable" resolutions (p. 580). In this case, the question centers on whether the client will benefit more from termination or the continuation of care.

Exploring countertransference in the therapy room

The authors present a case study to emphasize the clinical dilemmas clinicians might confront when a client's emotional struggles bump into those of the clinician's personal life. The case study brings attention to the parallel process that is bound to occur between the clinician and client; and the countertransference that emerges in response to relational patterns, adverse childhood events, traumatic experiences, and insecure attachments with caregivers. It explores the influence of this clinician's

negative core beliefs in response to her client's experiences, the intrapersonal and interpersonal conflicts, and the ethical and legal ramifications of initiating a premature termination.

Case study

Linda is a 35-year-old female pursuing treatment to manage her symptoms of anxiety which manifest in her inability to develop intimate relationships. Linda practices as a lawyer in a renowned law firm and despite acknowledging her skill, talent, and success, she reports feeling irritable, restless, and unfulfilled in her personal life. She refers to loneliness as her companion but is also not ready to commit to a relationship in fear that it will interfere with her productivity at work. While she has a strong relationship with her father, she displays much anger and disgust toward her mother. She constantly thinks about her mother's opinions and reactions to her decisions, worrying that she will disapprove, criticize, or judge her. This fear carries over to her interactions with men, as she constantly worries that they too will disapprove, criticize, or judge her. Evidently, she avoids engaging in meaningful interactions with men and will end a relationship as soon as someone displays romantic interest in her. Her resistance in the therapeutic relationship mirrors this core belief, as she has adopted the role of victim to rationalize and protect herself from exploring her adverse childhood experiences that dictate her current struggles.

After two years of treatment, Linda discloses that she has a rare medical condition that affects her daily functioning in a significant way. Mary, the clinician, is taken aback by this disclosure because, (1) Linda denied having any medical conditions in the intake process and (2) she has never alluded to this condition in any of their previous sessions or interactions. While Mary responds with compassion and curiosity in session, she is overwhelmed by this information and notices her anxiety in the room. Mary's response is personal as she was recently diagnosed with a rare medical condition. As Mary acknowledges the intensity of her emotions and begins to recognize her countertransference in the room, she grapples with question of, "Can I competently provide treatment to a client experiencing a parallel struggle or do I terminate the relationship in the best interest of the client?"

Although Mary's countertransference is rearing its head now, she has been struggling with complex emotions throughout the course of their work. Unclear to her at the time, Mary struggled to *like* Linda during their early months of treatment and often spoke about it in supervision. With time, Mary became aware that these struggles were rooted in her countertransferential feelings around Linda's dedication to remaining a

victim. Her successful attempt at working through these earlier feelings of countertransference confuses her more now as she wonders if it is possible under these circumstances as well.

The Clinician's countertransference

Following the client's disclosure, Mary shares her experience in supervision. She describes the similarities and differences between their coping mechanisms and the intensity of the pain she feels as she sits in the therapy room. Her problem, she tells her supervisor, is, "The pain I feel in session is more about my own losses than my client's, and therefore it interferes with my ability to be present with her." She further describes the anxiety she feels before their sessions, sharing that it is rooted in her fear of evoking her own biases and viewpoints onto her client. Mary also shares her concern about her personal pain surfacing in the room since it might impede her ability to properly support her client in the here-and-now of the therapy experience.

To complicate matters further, Linda's relationship with her mother mirrors Mary's relationship with her father. While Mary is married with two children and maintains a successful clinical practice, she notices that her body often contracts when Linda speaks of her ruptured relationship with her mother. Like Linda, Mary has a difficult relationship with her father who struggles with depression and is therefore often critical, cynical, and disconnected from the family. Mary deeply resonates with Linda's pain, but at the same time, she struggles to be a holding force in session because of her past relationships and recent medical trauma.

For many months, Mary processes her countertransferential experiences with her clinical supervisor. She considers terminating the therapeutic relationship because (1) she struggles to remain present in session because of her countertransference and (2) her medical condition is ongoing and the constant reminders in session are too painful. When discussing this conflict, Mary's supervisor repeatedly reassures her that she will support her decision either way; and whenever she doubts her ability to support Linda, she gently reminds her, "Your ability to model survival is everything for her right now."

A large part of Mary's work is distinguishing between her personal experiences and those of her client. It is often challenging to separate her own emotional experiences from those of her client. Through supervision and personal therapy, Mary learns that many of these experiences belonged to both of them. Yet, as part of her work, Mary needs to recognize the differences between their experiences so she can remain present in the relationship and therapy room. Exploring the different responses people have to illness and adversity based on adverse life events, attachment

styles, protective and risk factors, resources, and resilient outcomes are all imperative to her work. Most importantly, Mary needs to better understand her needs and to identify the benefits and consequences of continuing or terminating treatment. This conversation is ongoing and includes an exploration of the clinical, ethical, and legal ramifications of her decision. The main pointers of her supervision sessions are outlined below to emphasize the complexity of the process and the importance of working through countertransference to safeguard the needs of our clients.

Working through countertransference

Clinical implications

There are several factors playing a role in Mary's decision-making process. First, Mary needs to identify the commonalities and differences in their stories to distinguish between the client's self and her experience in the room. This is an important step in properly addressing her countertransference and clinical concerns. This work translates into recognizing the similarities and differences between their relationships with parental figures, coping styles, resources, personality traits, and response to their diagnoses. For instance, when Mary received the diagnosis, she sought the best practitioners in the country for treatment. She researched, networked, and tried several treatments to alleviate the pain and minimize the short-and-long-term effects of the disease. She continues to meet with her medical team and is constantly engaged in further research to expand her understanding of the condition. By contrast, Linda has not seen a medical practitioner since she received the diagnosis during adolescence. She does not have a treatment plan, nor does she visit her primary care physician on an annual basis. Her avoidance is triggering Mary for many reasons: she chose to be an active participant in her treatment, she is aware of the ramifications of her client's neglect and avoidance, and her behavioral patterns are a reminder of her elderly father who does not seek the appropriate care for his diabetes. As mentioned earlier, Mary also experienced a countertransferential response to Linda's dedication to a life of victimhood since the beginning of their relationship and it continues to resurface throughout the course of their work. A part of Mary's work is to recognize that here too, her anxiety is being elicited in response to her client's denial and avoidance. She needs to work with the projective identification that continues to exist and to process her anger and frustration in response to being misled about Linda's medical history.

   To deepen her ability to stay with Linda, Mary also needs to process her feelings of helplessness in face of Linda's avoidance. Through exploration, Mary's supervisor is able to help her recognize the dual process

that is occurring in the room. The sense of helplessness she feels isn't her own, it is Linda's feeling of helplessness that is being projected and evoked within her. The projective identification that is transpiring is disrupting her ability to stay present and grounded in session, making her want to run away from the case just as Linda wants to run away from her problems that brought her to the therapy room in the first place. Understanding this process allows her to consciously exit the battlefield so she can properly align with her client's needs.

In addition, Mary needs to consider the therapeutic relationship and the potential damage she might cause by continuing treatment or by initiating a premature termination with Linda. The client's background, attachment style, symptomatology, support system, and resources need to be carefully assessed (Dalenberg, 2005). Based on the case conceptualization, it is clear that Linda presents with an anxious-ambivalent attachment style. This is seen in her ambivalence to connect with her clinician as well as with significant others outside of the therapeutic relationship. As attachment theory explains, people develop an internal working model based on earlier attachment with caregivers and when there is a disruption of safety, an insecure attachment might present as anxious ambivalence (Bowlby, 1988). This complicates an individual's ability to connect securely with others as well as to regulate distressing emotions. As noted, Linda presents as highly dysregulated and is often unable to access her resources to manage her anxious symptoms. Although Linda lives with supportive friends, she struggles to seek their support in fear of being a burden but then imposes on their space when she feels uncertain and overwhelmed. Linda engages with men until they display romantic interest in her and then self-sabotages by abruptly ending the relationship because of her fear of intimacy. She often seeks support from her father, but the absence of a relationship with her mother severely impacts her ability to authentically connect with others. Evidently, this shows up in the therapy room in the way she cancels sessions at the last minute, demands special attention, and engages in the constant push and pull where she alternates between seeking and avoiding connection. This is mentioned because it plays a role in the therapeutic relationship and Mary's decision-making process. For a successful therapeutic outcome, Mary needs to recognize and own her attitude toward Linda's behaviors, and work through her impatience, exhaustion, and frustration in supervision.

Lastly, and most importantly, Mary needs to evaluate whether she has the emotional bandwidth to support Linda through a seemingly parallel journey. Poorvu (2015) discusses this idea in depth, particularly in regard to clinicians living with physical illnesses. He explains clinicians need to consider whether they will disclose their illness to their patients and how the changes in their use of self might impact the therapeutic relationship.

While Mary believes it is unhelpful to disclose her condition at this point in time, it is something for her to consider as she continues to work with Linda. That is, when choosing to disclose aspects of illness, the clinician needs to carefully consider what would be helpful for the client and when it would be helpful for the client. The decision to self-disclose, including the timing and choice of words, are very important elements of the process (Marin, 2019). The disclosure needs to be made with the intention to provide relief to the client, not the clinician, and at this time it would be to free Mary from the projective identification taking place in the therapeutic space as opposed to deepening the connection and experience for the client.

Ethical implications

Continuing treatment when a clinician is unable to competently provide services creates an ethical dilemma. Indeed, a core aspect of ethical practice revolves around countertransference experiences as clinicians juggle responsibility, judgment, and truth (Wilson, 2013). Consequently, Mary is conflicted about whether to continue working with Linda or to terminate services prematurely. Continuing to provide services honors the ethical principle of *service*, but it could also potentially lead to a misuse of service. According to the *Code*, social workers have an obligation to act in alignment with the client's best interest. The *Code* also states that clinicians need to act with integrity and competence (NASW, 2021). However, terminating services prematurely seems to minimize the importance of human relationships and honoring the dignity and worth of Linda. The dilemma between the continuation or termination of services often surfaces when a clinician and client are experiencing similar phenomena. This is better understood in the context of the aftermath of Hurricane Sandy, COVID-19, and the current war in the Middle East. In light of such events, previous experiences of countertransference collide with universally shared experiences, and clinicians need to hold their personal experiences and those of their clients. While Mary's experience appears more intimate as it relates to a more personal and private challenge, she is ultimately struggling to discern between the principles of beneficence and non-maleficence as she is unsure whether to act paternalistically or to err on the side of caution to assure no harm. The weight of ethical burdens is heavy; and yet, they are unavoidable in this line of work.

Legal implications

When resolving this ethical dilemma, Mary needs to consider the legal implications as well. A premature termination or the continuation of

treatment could lead to litigation. That is, if continuing treatment causes Mary to behave unethically, Linda might report Mary to the licensing board. However, Mary could also choose to report the untimely termination of their therapeutic relationship. In a worst-case scenario, premature termination, or an unsuitable course of therapy, could lead to an increase in symptomatology or suicidality. This outcome could most certainly result in a lawsuit or disciplinary procedures before a licensing board.

Reaching A decision

Despite Mary's intense emotional and somatic responses to her client's disclosure, she chose to continue working with her. As mentioned previously, Mary felt that it was imperative for her to consider the clinical, ethical, and legal implications when choosing to either continue treatment or initiate a premature termination. Once Mary began to process these aspects of the work in supervision, she was able to address her own grief, pain, and anxiety that was emerging in response to her client's medical diagnosis in her personal therapy. Although this has been an ongoing process for her, this experience added a new dimension of depth to their work as Mary needed to explore and process what it was like for her to support someone else through a strikingly similar experience. Making the decision to continue treatment was difficult and complex; however, it is important to note that she was only able to come to this place of clarity from working through her struggles in clinical supervision and personal therapy. With time, Mary noticed her anxiety diminish prior to, during, and in-between her sessions with Linda. Like she shared with her supervisor, "It's not gone completely, I still check-in with myself every session, but it feels less overwhelming because I am okay with it. Now I know it's the human part of me in the room and that I don't need to get rid of it. I only need to learn how to make space for it." As mentioned previously, a significant part of addressing countertransference is honoring the clinician's humanity in the room and using it as a means to deepen the work. Moreover, as Freud (1910) stated, it is advisable for clinicians to seek therapeutic counsel to expand self-awareness and reduce the blind spots in their work.

Conclusion

The relationship between the clinician and client is a critical component of psychotherapy. The exchanges between the clinician and client are often used as a tool to resolve the issues that bring the client into therapy (Dalenberg, 2005). Due to the significance of the relationship, issues of countertransference are an important source of information for the

clinician and need to be addressed so as not to hinder the therapeutic process (Barreto & Matos, 2022; Frayn, 1992; Westerling et al., 2019). As stated previously, countertransference is not an indication of incompetence but is merely information to be processed to deepen the work. Yet when these experiences are denied or avoided, it becomes increasingly complex to manage the upheaval they might cause and are more likely to result in an impasse or untimely termination.

When clinicians engage with clients, they are bound to experience issues of countertransference and therapeutic impasses. It is therefore essential that the literature provides the language to describe these experiences to lessen the feelings of guilt, shame, and uncertainty that tend to emerge through these processes. This clinical note aims to provide a review of these constructs through a case study to emphasize the clinical, ethical, and legal dilemmas clinicians encounter when they experience counter-transference in the course of therapy. While experiences of countertrans-ference are intimate and painful for the clinician, they are bound to happen; and it is the clinician's duty to address these issues while simul-taneously prioritizing the clinical, ethical, and legal standards of the *Code*. Ultimately working through these feelings and ethical considerations will lend itself to greater clarity and more successful therapeutic outcomes beyond the clinician's work with a given client.

Disclosure statement

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