members-only area where AET members can network and support each other via bulletin boards, discussion groups, an exchange of business-to-business services—such as job listings—and a searchable up-to-date membership directory. We envision abstracts and downloadable articles from the *Educational Therapist* archives, easy and convenient online membership renewal, and tape and publications purchases.

Finally, a more informative Web site will create greater public awareness of the services that educational therapists provide, how educational therapy differs from tutoring, and when it might be desirable for parents or schools to engage an educational therapist.

At the time of this writing, a volunteer committee of the AET Board is hard at work developing a Web site with an updated look that will make all AET members proud. An informative, dynamic Web site has enormous and exciting potential to attract newcomers to the profession and support educational therapists and allied professionals in the delivery of quality services. We will keep you informed of the Web site's progress. Watch for the new AET Web site to appear in the coming year!

Some Thoughts on the Role of Countertransference in Educational Therapy

Ann Gordon, M.Ed., Ph.D.

Like many of my peers, I regularly find myself overtaken by powerful emotional reactions that mystify me and have enormous impact on my work. Sometimes that impact is positive, and sometimes not. Probably the most useful advice I ever received was from a clinical social worker in Chicago, Steffa Mirel, who suggested that I consider such reactions as sources of information about my clients, and about me. This advice launched me on the search that led to my current work.

This paper shares with you some lessons I have learned from thinking about countertransference as it pertains to my work as an educational therapist. First and foremost, this is a personal search for understanding—a search that is inherently provisional and ongoing. However, while personal, it is not a search that I engage in alone. Most valuable are the discussion groups I have been a part of over the years in which participants willingly and often painfully discuss these issues, usually with the help of a facilitating psychotherapist. Someday I hope to put together an educational therapy countertransference case book in which the lessons learned in these groups can be shared more completely. In the meantime, here is a bit of my own story, beginning with my current understanding of some of the *big* ideas involved.

Countertransference

Countertransference has historically referred to the therapist's reactions to the transference of his or her patient. More broadly, countertransference is the complete set of feelings we have in response to students, their families, caretakers, and other involved professionals. It is not possible to have any interaction with another person without having some kind of emotional reaction to that person; a reaction to something that was done, said, felt, or thought. The reaction may come from something triggered from our own past or inner world, or it may be the shared experience of something felt by the other. In either case, these reactions of one person to another are spontaneous emotional reflexes that are not under conscious control and of which we are not always aware.

Countertransference experiences can thus be thought of as the unconscious exchange of emotional information between two people. This exchange of information has an enormous impact on how we interpret what others say, how we feel, and how we ultimately act.

Because of the impact of countertransference on our behavior, treatment technique and countertransference are inseparable (Giovacchini, 1989). This is as true in the practice of educational therapy as in the practice of psychotherapy.

The Old Days

There was a time when psychotherapists believed that they were not supposed to have reactions like these, or, at least, that such reactions should be kept to a minimum (Freud, 1910). The model, drawn from the world of medicine, was that the psychotherapist was the doctor and the client was the patient. The doctor was there to understand and fix the patient and the patient was there to be fixed. The concern was that the emotional reactions of the therapist to the patient would intrude upon and interfere with the intrapsychic work of the patient as revealed in transference onto the therapist. Therefore, psychotherapists studied and talked about the role of transference in their practice, and gave less of their attention to the role of countertransference. So first, let's discuss, very briefly, transference.

Transference

Transference is the process by which emotions that a client associates with one person, such as a parent, unconsciously shift to another, as a therapist. Transference refers to the one-way projection of some image onto someone else—a process that leads the individual to respond to that person as a stand-in for someone else, usually a person from his own past, without recognizing the stand-in as a person in her own right. For example, most of us who work with children have had the experience of the youngster who slips and calls us "Mom" or "Dad." At that moment, the child is responding to us as if we were indeed the person who is that child's parent. In that same moment, the child has "forgotten" who we really are. Often the child is a bit flustered when this happens, and sometimes we react with embarrassment as well. It is as if we were both caught revealing a secret. Most often, in a case like this, we both just go about our business, as if the exchange had never happened. We may tell others about it, as an amusing story and as evidence of the attachment felt by the child.

For therapists, this interaction and what it represents has historically been a whole different matter. For the traditional psychoanalyst, for example, transference and the interpretation of transference are considered the primary events of therapy. These events are, in fact, taken to be the mechanism of psychological change in the patient.

Countertransference Persists

Over time, many therapists came to realize that in spite of their best efforts, they continued to have those pesky emotional reactions which impacted how they interacted with their patients. These feelings just didn't go away, regardless of how hard the therapists worked to eliminate, or at least neutralize them. Then some members of the profession began to take another look at these reactions. They began to view their emotional reactions as a source of important information that could be used to further, rather than impede, the therapeutic process (Hamilton, 1990, p. 235).

The change in attitudes toward countertransference was the result, in part, of the emergence of a new paradigm borrowed from the world of philosophy and supported by research on the reciprocity and mutual influence in infant-caretaker interactions. This new paradigm represented a shift in focus from intrapsychic (*within* psyche) phenomena to interpsychic (*between* psyches) phenomena, in recognition of the fact that there were actually two individuals in the therapist's office, not just one (Ogden, 1982). What was going on within each of the individuals subjectively, as well as what they thought was going on between them, was beginning to be seen as relevant to whatever change might be expected to take place as a result of their work together. The form this change in outlook took, and the ways in which it was interpreted, differed markedly across theorists—but for the purposes of this paper, countertransference, or the unconscious communication of information between a client and therapist, emerged as a primary concern.

Countertransference and Educational Therapy

As a result of this paradigm shift in the field of psychotherapy, the practical and psychological value of understanding countertransference became familiar to many psychotherapists, but these ideas and their implications remain less familiar to educational therapists or other educators. This is not surprising, since courses in the theory or practice of psychotherapy are rarely required in education programs.

While the formal theories may not be familiar, what is known to anyone working with children is the raw experience of having quite surprising and often very forceful feelings. These feelings are just as likely to be positive as negative. Sit in any teacher lunchroom, talk with any group of learning specialists, or engage in any more formal review of practice with educational therapists, and you will often hear emotional struggles like these:

- Originally, I was worried about the child, worried about what I could do, *and* irritated. Now, I'm not worried, I'm just irritated.

- I have sweaty palms just thinking about this case. This kid's parents always get so condescending!
- She is just such a wonderful kid—so creative, articulate, spirited. I just don't see *why* her parents don't get it! I'd take her home in a minute.
- The first day I was scheduled to see this student, the mom showed up early. I was putting my groceries away. The child entered my house like a bat out of hell, going through my groceries, wanting to know—I mean he was just off-the-wall—wanting to know why I bought this and did I buy that. He was just so annoying!
- This student is the child of a very high-profile family. And they have this enormous sense of entitlement, and they want everything done yesterday, and they don't want to be on any waiting list, or go through any of the same hoops that anybody else has to go through, because they are who they are.

Educators are not shy. They know they have reactions like these to students, parents, administrators, and other teachers, but there is little in their training that helps them know what to do with their feelings. So they take them to their peers, share them with their partners, tell stories about them to anyone who will listen, but they rarely think of them in terms of what these reactions might be telling them about themselves or about the other person.

In the example presented earlier, an educational therapist might well have some emotional reaction to being called "Mom" or "Dad" by a child. This emotional reaction could be expected to differ among individuals. It is reasonable to assume that the educational therapist's reaction might be determined in part by her own past experiences and emotional make-up, and in part by what she takes in, unconsciously or nonverbally, of what the child's "slip of the tongue" was communicating. In other words, whatever else was going on, this rather everyday exchange represents an emotional dialogue between two people that could have a multitude of subjective meanings for each participant.

Understanding this dialogue is important because our unconscious reactions should not be allowed to hinder the child's progress or growth. More positively, these reactions can help the therapist learn something about the child that the child might have no other way to communicate. Furthermore, the educational therapist can examine these dialogues as a way to further her understanding of herself. Work with children is often stressful and pressured and is known by all to produce strong internal reactions (Chethik, 1989, p. 23). In the end, the more conscious the educational therapist is both of what might be going on for the child and what might be going on for herself, the more intentional and "therapeutic" can be her response. For example, if the educational therapist found herself feeling entirely uncomfortable for some reason that she didn't examine, and in that state of discomfort she reacted in a way that was distancing or judgmental, what started out as a connection might well end up as an instance of rejection.

Informed Practice: A Case Example

Joshua is an 11-year-old student whom I have been seeing for 2 years. He first came to me because he was having difficulty keeping up with the math curriculum at his new school. It was love at first sight. He was entirely engaging and I was taken with him. His mother, a single parent, was like an old friend, and I delighted in the prospect of working with her. I looked forward with confidence to what I expected to be a very productive therapy.

By the end of the first year of treatment, it was becoming apparent that things were not as simple as they first appeared. Joshua had periods during which he refused to go to school, he and his mom fought with surprising energy at home, and I found myself circling the wagons around Joshua in an effort to protect him from all threats. He was described as stubborn, hostile, and assaultive at home, and disrespectful, resistant, and disruptive at school. He did little to no homework at home and little work during the school day, and he did terribly on tests in pretty much all subjects. I spent many hours on the phone with his mom, in an effort to "explain" Joshua's behavior to her. I made frequent trips to his school, in an effort to get them to make the accommodations I thought were needed.

My in-session time with Joshua was always a delight. I never saw the child that his parent or teachers described. We cheerfully discussed modern art, the latest book he was reading, and my resident box turtle's well-being. Joshua was clearly very intelligent, interested in the world, and surprisingly sophisticated for his age. He didn't strike me as particularly anxious. When he was with me, he appeared to be putting forth good effort, got a lot of work done, and appeared quite "normal."

I did notice that he often did not tell me all that he had to do until we were near the end of our time together. His pattern was to come into the office and tell me what had to be done, and I would act as if everything was fine and manageable. About 10 minutes before the end of our time together, he would let me know that there was also some test coming up for which not yet studied, or a paper due that he had not started. We would try to extend the time so that he could do what he had to do, and I would feel like an idiot for not asking the right questions to start. He would always leave telling me that he could get the rest done at home.

I realized that I had some unconscious need for everything to be okay, and that I wasn't paying attention to the distortion that my need was adding to the mix. In other words, I wasn't actually seeing him, I was seeing what I wanted to see. As a result we kept blindly repeating this drama over and over. He wasn't getting the help he needed, and I was feeling increasingly bad. That is not to say there wasn't value

in providing this child with a warm, stable, positive holding environment—it is only to say what was being ignored along the way was also important.

I realized that I was taking on a great deal more than I needed with this case, and I was giving this child a great deal more help to complete his work than I normally do. In fact, if truth be told, I was doing a good deal of his work for him. I soon discovered this was exactly what his mom had been doing as well. It became clear that we were all doing more than his homework for him.

As the light dawned, I stepped back and began to control more consciously how much help I gave him. I still provided a warm and accepting environment, but I focused more on supporting his capacities. And as I did so, I was stunned to see another child emerge. One day, he was studying for an exam, and he simply crashed. I had seen him withdraw before, but nothing like this. It was as if all his systems shut down. It was actually scary. I couldn't get him to talk, I couldn't re-engage him in anything. I couldn't distract him out of his state. The shutdown was rock-solid and rigid. I felt as if there was a huge boulder of rage rolling around the room and I sure didn't want to be in its way. This turned out to be a common event at home and at school—one I had not seen, no doubt, because of how well something in me functioned to keep this from our mutual experience.

We never had a repeat of the crash during our sessions, but knowing about that part of him did change things. I got a peek into the terrified part of Joshua and never again took his "I'm alright" presentation at face value. I also realized this child needed a good deal more than I could offer—not instead of the work we were doing together, but in addition to that work—and I began a long and frustrating effort to get him to see a therapist. Each time I thought we had something set up, a glitch would emerge. He would have a panic attack and refuse to go, his mother would forget the appointment, she would change her mind, the issue of finances would come up, or the times just didn't work. This went on for a year. Throughout that year, he and I remained as close as we had ever been—although there was now an added voice in my head urging me to step back ever so slightly whenever possible.

As I reflected on this case during a countertransference discussion, I talked about how frustrated I was that the mom was not more aggressive about getting her son into therapy. And then I realized that it might be a bit about me too. Maybe it was I who was not ready to give this child over to someone else. Maybe it was I who was holding on to him, enjoying being the "good mother," basking in his adoration, feeling validated by his progress, joining in his rebellion against his mother, sharing in his resistance to his parent's choices of treatment. In doing so, I behaved in ways that sabotaged the work of getting this child the therapeutic help he needed—and all the while I thought the mother was doing the sabotaging!

Some of this story turned out to be about me—my own childhood, my own experiences and needs. And some of this was about the child—his uses of me, what he was communicating to me about who he wanted to be, but wasn't—and about all the terrible feelings he was working so hard to control.

Now, why would these revelations make any difference? For one thing, it is likely that proceeding the way I had been would never have resulted in Joshua finding and establishing a solid relationship with a therapist. Becoming more aware of what I was doing meant that I could change enough to free him to do what he needed to do. For another thing, the frustration and anger toward the parent that I had begun to feel was building to a level that drained a great deal of my energy from this as well as from other cases. As I talked about this case, I began to see my anger at the mother as over-identification with Joshua. With this insight I was able to move to a more moderate position, and the anger dissipated.

As long as I looked at the parent as the source of the problem, there was little I could do to effect change—but the moment I began to look at myself, there were all sorts of things that I could do differently. The end of this story is that after a few false starts, this child did enter therapy and established a very productive relationship with the therapist.

The Educational Therapy Countertransference Checklist

Cases like this were discussed in a consultation group in Oakland in which I participated.

In that group we decided to look at the psychological literature to see what we could learn about our reactions, with the idea that we would explore how that literature might apply to our work. In addition to gaining insight into our reactions, we discovered lists of countertransference indicators, and thought we might try our hand at generating a list for ourselves, which we did. That list has evolved into The Educational Therapy Countertransference Checklist, a 32-item form that has since been used as a tool to help educational therapists and others identify and talk about the reactions they have as part of their practice.[1]

The following are some of the indicators included on this form:

- I have overextended myself and loosened my normal professional boundaries in my initial interactions with the student, family, or referral source(s).

- Working on this case has led me to question my professional competence as a learning specialist.

- I experience more than the usual amount of pleasure, pride, or other positive reactions out of seeing the student, parent, or guardian.

- I have dreams or nightmares, persistent thoughts, ruminations, or obsessions about this case.
- My comments toward the student or the student's family are generally sharper, more argumentative, impatient, controlling, or pressured, than is my normal style.
- I talk excessively while with the student's family or disclose facts about myself that are unnecessary.
- I exert excessive efforts during the sessions, even to the point of becoming exhausted or irritated.

Conclusion

So, what are the lessons here? The biggest ones are the following: we need to pay attention when we are feeling stuck on a case; when our view is radically different from the views of others working with the same child; or when we find ourselves particularly disturbed or particularly attached. In other words, when we have any kind of strong emotional reaction as part of our work, it is time to stop and examine that reaction for what it tells us about how we are relating to others, and how they are relating to us. We want to check out what impact those reactions may be having on the way we are working with a particular individual. In the end we want to run, not walk, to some form of supervision or consultation. It is not enough to talk to friends or share stories. We owe it to our clients and to ourselves to get help from a professional. One way to do this is to be part of an ongoing group facilitated by a therapist, another way is to be in therapy ourselves, and a third is to have a consultant available that we use as needed.

References

Chethik, M. (1989). *Techniques of child therapy: Psychodynamic strategies*. New York: Guilford Press.

Freud, S. (1910). T*he future prospects of psycho-analytic therapy*. Standard Edition 11: 141-151.

Giovacchini, P.L. (1989). *Countertransference triumphs and catastrophes*. Northvale, New Jersey: Jason Aronson.

Hamilton, H.G. (1990). *Self and others: Object relations theory in practice*. Northvale, New Jersey: Jason Aronson.

Ogden, T.H. (1982). *Projective identification and psychotherapeutic technique*. New York: Jason Aronson.

Dr. Ann Gordon, Certified Educational Therapist, earned her M.Ed. in special education and Ph.D. in educational psychology from the University of Illinois at Chicago. She received training in the diagnosis and treatment of organically based learning difficulties at the Multidisciplinary Institute for Neuropsychological Development, Inc. in Cambridge, Massachusetts. She is currently a postdoctoral student in clinical psychology at the Fielding Institute; the director of Educational Services Associates in Oakland, California, and the President of the Board of Directors of the Ann Martin Children's Center in Oakland. Ann often contributes articles to the Educational Therapist.

[1] Owing to space constraints, this form is not included here. For further information, you may contact Ann Gordon by e-mail, at agordon@edservices.org.