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Utilizing Interpersonal Process Recall in Clinical Supervision to Address Counselor Countertransference

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Abstract

Counselors' countertransference responses may interfere with their abilities to form therapeutic alliances necessary for desired therapeutic outcomes. Interpersonal Process Recall (IPR) is a supervision strategy that may be utilized in clinical supervision to address counselor countertransference. IPR entails a focused review of specific sections of recorded clinical material, with attention to using discovery-oriented process questions to reformulate previously unnoticed but significant moments in-session. A brief overview of counselor countertransference is provided, followed by a description of the IPR technique and case example illustrating its application to addressing counselor countertransference within a clinical supervision session. Considerations for clinical supervisors utilizing IPR are also suggested.

Therapeutic alliance is the most important common factor associated with therapeutic outcome (Lambert & Barley, 2001). When adequately established, the therapeutic alliance is beneficial for the client in and of itself, correlating positively with therapeutic outcome regardless of the specific treatment or techniques applied (Martin, Garske, & Davis, 2000). As outlined by Bordin (1994), three components contribute to therapeutic alliances: (a) agreement on therapeutic *goals*, (b) agreement on therapeutic

tasks to achieve these goals, and the (c) *bond* between the client and counselor. To achieve strong therapeutic alliances, counselors seek to empathetically conceptualize and approach goals in a mutually agreeable way with clients within the context and boundaries of therapeutic relationships. Collaborative client-centered therapeutic alliances require the extension of unconditional positive regard, accurate empathy, and counselor congruence (Rogers, 1961). Therapeutic alliances are inherently intimate, while carefully attending to ethical parameters defining client-counselor relationships (American Counseling Association, 2005).

Although therapeutic alliances are shaped by relational contributions of both the client and counselor, the present article focuses on the counselor's influence upon the relationship, as this domain may be most readily accessible within clinical supervision. Personal attributes of the counselor positively contributing to therapeutic alliances include: flexibility, honesty, respectfulness, trustworthiness, confidence, warmth, genuine interest, and openness (Ackerman & Hilsenroth, 2003). Therapeutic alliances are also fortified by the counselor's technical application of exploration, outcome-focused activities, facilitative expression of affect, reflection, accurate interpretation, and attention to the client's experience in therapy, past and present (Ackerman & Hilsenroth, 2003; Bedi, Davis, & Williams, 2005).

Countertransference is defined generally as the counselor's emotional and/or behavioral responses to a client that are based on the counselor's unresolved conflicts (Hayes & Gelso, 2001). It is an interpersonal relationship dynamic that may detrimentally impact the formation of strong therapeutic alliances and consequently, therapeutic outcomes (Hayes, 2004). Interpersonal relationships, including therapeutic alliances, are often characterized by approach-avoidance patterns (Rosenberger & Hayes, 2002). People need each other, but also learn to fear one another. This process contributes to a search for safe distance in relationships. In the context of clinical dyads, countertransference may contribute to counselor actions characterized by both approach (i.e., over-identification with a client, diplomatic behavior) and/or avoidance (i.e., tuning out clinical messages, surface-level conversations) aimed to mitigate relational discomfort (Hayes, 2004; Rosenberger & Hayes, 2002). Consequent clinical distance may interfere with the formation of therapeutic alliances necessary for therapeutic effectiveness and the counselor's provision of core conditions for therapy (Rogers, 1961). Thus, although counselor's affective engagement with clients is normative and considered necessary to the therapeutic process, attention to understanding and managing unproductive counselor countertransference reactions is warranted.

Interpersonal Process Recall (IPR) is a supervision strategy developed by Norman Kagan and colleagues (1980) that can be applied in clinical supervision to assist counselors in becoming more attuned with interpersonal relational dynamics in therapeutic alliances, including countertransference. Within supportive and exploratory clinical supervision contexts, IPR facilitates a focused review of recorded counseling sessions with specific here-and-now attention to covert thoughts and feelings (Cashwell, 1994). Concurrent to video review, discovery-oriented reflection questions are purposefully utilized by the supervisor toward processing significant moments in clinical sessions. A primary goal of IPR is to enhance counselor self-awareness and monitoring of relevant interpersonal relationship dynamics and therapeutic processes.

Considering the focused attention IPR brings to highlighting, understanding, and confronting interpersonal fears and relational responses, this technique is particularly suited for addressing counselor countertransference within clinical supervision sessions. A brief overview of countertransference, including its relationship to therapeutic alliances and therapeutic outcomes will be provided. Next, IPR will be substantiated as a supervision strategy to address counselor countertransference. A detailed description of the technique process will then be provided, as well as a case example that illustrates the application of IPR to addressing counselor countertransference within a supervision session. Finally, suggested supervisor considerations for the use of IPR within clinical supervision will be forwarded.

Definition of Countertransference

As originally defined by Freud (1910/1959), countertransference was viewed as the analyst's unconscious, conflict-based responses to client transference. In contrast, Freud believed therapeutic alliances to reflect the positive transference from the client to the analyst. Within this *classical conceptualization*, countertransference was perceived as interfering with the analyst's ability to serve as a "blank screen" (Freud, 1910/1959) for the client and, thereby, was to be avoided or eliminated at all costs (Hayes, 2004).

As part of the evolution of psychotherapy theory and research, a second, more *totalistic conceptualization* of countertransference emerged that considered both the client's and counselor's contributions to this dynamic, as well as the potential therapeutic utility of the counselor's affective responses in-session (Gabbard, 2001). Within the totalistic definition of countertransference, the key task of the counselor is to "understand what clients are eliciting from them and not act impulsively on countertransference feelings but rather respond thoughtfully and intentionally" (Hayes, 2004, p. 22).

Some critics of the totalistic definition of countertransference argued that this conceptualization might lead to client blaming and brings attention away from the counselor's role in the process (Brown, 2001; Safran & Muran, 2000; Hayes, 2004). Consequently, a third, *integrative conceptualization* (Gelso & Hayes, 2002; Hayes, 2004) posits the source of countertransference reactions as residing within the counselor. The primary onus therefore falls on the counselor to take responsibility for these actions and to actively work to understand and manage countertransference responses. This integrative definition of countertransference also expanded on Freud's classical conceptualization to include both conscious and unconscious counselor responses to clients. Further, counselor countertransference is viewed as potentially originating from unresolved conflicts, but may also stem from other processes transpiring within the therapeutic context (Gelso & Hayes, 2002; Hayes, 2004).

Countertransference Behaviors and Therapeutic Alliances

Counselor countertransference behaviors have been operationally defined as avoidance of client material or withdrawal from personal involvement (Ligiero & Gelso, 2002). Kiesler (2001) differentiated two types of countertransference, subjective and objective. Subjective countertransference refers to the counselor's reactions to the client that stem from the counselor's own anxieties. Objective countertransference entails reactions that are evoked by the client's maladaptive behavior. If detected, objective

countertransference can provide a window to critical client dynamics influencing the therapeutic process and may be integrated into treatment. With both subjective and objective countertransference, recognition of counselor responses is critical, as potentially damaging actions may follow if these processes are not identified and appropriately addressed (Kiesler, 2001; Ligiero & Gelso, 2002).

Countertransference behaviors may manifest as positive or negative counselor responses (Friedman & Gelso, 2000). The former category encompasses counselor behaviors that may appear supportive or friendly, but ultimately serve the counselor's needs and/or avoid client issues. Examples of counselor positive countertransference behaviors may include over-agreement with clients, excessive or non-therapeutically-oriented self-disclosures, or befriending clients. In contrast, counselor negative countertransference behaviors include acts to minimize discomfort in session, such as being overly critical, punitive, or rejecting of clients.

In a study exploring the relationship of counselor countertransference behaviors and therapeutic alliances, Ligiero and Gelso (2002) administered therapist and observer versions of the Working Alliance Inventory (WAI-Therapist; Tracey & Kokotovic, 1989; Working Alliance Inventory-Observer; Tichenor & Hill, 1989) and two measures of countertransference (Countertransference Index, CT; Hayes, Riker, & Ingram, 1997; Index of Countertransference Behaviors, ICB; Friedman & Gelso, 2000) to 50 master's- and doctoral-level therapists-in-training and their respective clinical supervisors. Therapist attachment style was also assessed in this study but not found to significantly relate to either therapeutic alliances or counselor countertransference behaviors.

Overall, the findings reported by Ligiero and Gelso (2002) in this study supported a significant relationship among countertransference behaviors and therapeutic alliances. Specifically, counselor countertransference behaviors were associated with poorer working alliances, as rated by both the counselors and supervisors. Further, negative countertransference behaviors appeared to impact both the overall quality of therapeutic alliances, as well as the individual components (goals, tasks, bond) contributing to this relationship. Interestingly, counselor positive countertransference behaviors were negatively related only to the bond component of therapeutic alliances and only as rated by the supervisors. Disagreement between supervisor and counselor ratings of the bond component of therapeutic alliances was also predictive of countertransference behaviors (Ligiero & Gelso, 2002). Collectively, these results provide empirical support for the potentially deleterious effects of countertransference on therapeutic alliances. The findings also suggest that countertransference may interfere with counselor assessments of the quality of therapeutic alliances. More specifically, counselors and clinical supervisors may also differently assess therapeutic alliances and countertransference; thus, these topics are particularly important focuses for explorative discussion within clinical supervision sessions.

Managing Countertransference Behaviors

Considering both the centrality of therapeutic alliances to therapeutic outcomes and the impact counselor countertransference can have on the formation of therapeutic relationships, attending to, understanding, and somehow managing countertransference responses is warranted. Extant literature supports a positive relationship between counselor management of countertransference behaviors and therapeutic outcomes

(Gelso, Latts, & Gomez, 2002). Additionally, supervisors' ratings of therapists' capacities for self-monitoring, marking of appropriate therapeutic boundaries, and empathic responses appear inversely correlated with counselor countertransference behaviors (Hayes et al., 1997).

Some researchers have proposed five personal attributes that may play a role in helping counselors manage their countertransference (Gelso & Hayes, 1998; Gelso et al., 2002). First, therapist *Self-Insight* refers to the clinicians' awareness of their own feelings and understanding of the motivations underlying these feelings. *Self-Integration* describes levels of recognition of the boundaries between self and client. *Anxiety Management* is the extent to which counselors are able to effectively control or manage their own anxiety. *Empathy* refers to the counselor's abilities to conceptualize the client's experience and be attuned to emotional processes. Finally, *Conceptualizing Skills* entail the counselor's ability to conceptualize client dynamics and the therapeutic relationship.

The capacity for counselor meta-cognition, or the ability to conceptualize what one is thinking about, appears to undergird each of the five personal counselor attributes central to managing countertransference behaviors. Engagement in self-reflection better equips counselors to develop adequately vibrant cognitive frameworks for the complexities inherent to clinical practice, including managing countertransference responses. Specifically, counselors enacting meta-cognitive reflection about session content are less likely to conflate the client's point of view with their own and are better able to "see through" surface-level explanations to identify and utilize in-session patterns, even if unstated (McAuliffe & Lovell, 2006). Additionally, counselors employing meta-cognitive reflection are more adept in flexibly attending to both the process and content of therapy, tolerating ambiguity, and employing deliberate action in session (McAuliffe & Lovell, 2006).

Rationale for IPR as a Supervision Strategy to Address Counselor Countertransference

IPR has demonstrated effectiveness across multiple supervisory contexts including individual supervision, live-supervision, and group supervision (Huhra, Yamokoski-Maynhart, & Prieto, 2008) suggesting high treatment potency and flexibility. Consequent to IPR's purposeful and focused attention on significant moments transpiring in-session, the technique permits access to clinical processes that may be inaccessible through other supervision methods, such as unstructured review of recorded sessions, self-report, and formal assessment of clinical efficacy. Unique benefits of IPR include: (a) cueing memories or processes that would not have come to mind unassisted, (b) slowing down clinical interactions in order to give time to reflect and articulate complex experiences, and (c) focusing on particular moments versus retrospective generalizations (Larsen, Flesaker, & Stege, 2008).

IPR brings attention to significant moments in-session that might have been missed due to counselor countertransference responses. The self-awareness and reflection related to counselor countertransference that is promoted by the use of IPR is important to clinical practice and counselor well-being for several reasons. First, IPR facilitates self-reflection toward confronting fears (Kagan, 1980). If fears are not confronted, counselors' blind spots may unknowingly be perpetuated or exacerbated. Additionally,

fear can lead to counselor self-protection and, consequently, ineffective outcomes and burnout may occur. Second, IPR facilitates enhanced understanding of complex interpersonal relationship dynamics, including countertransference-based patterns. Counselor reflexivity is essential as critical self-reflection differentiates clinicians who burn out or stagnate from those who continue to grow and develop (Stoltenberg & McNeil, 2011). Counselor capacities for self-monitoring, a crucial goal of supervision, are also promoted (Bernard & Goodyear, 2008). Through re-processing critical incidents in-session, less effective relational dynamics are transformed, thereby, enhancing counselor propensities to form the TAs necessary to achieve desirable therapeutic outcomes.

Implementing IPR Intervention Within Supervision

Before initiating IPR interventions within clinical supervision, establishing a supportive supervision context creates a beneficial learning environment. The goal of IPR interventions is not to *teach* counselors about what could have been done differently; rather, the goal is to allow supervisees to *explore* previously unnoticed thoughts and feelings toward some resolution. As such, a learning-by-discovery philosophy should be introduced and adopted across supervisory interactions. Kagan (1980) suggested a supervisor tone that is assertive, and even confronting, but consistently and authentically non-judgmental. Meta-cognitive reflection is emphasized, toward an overarching goal of equipping counselors to more effectively self-monitor in-session dynamics in the future.

The following steps outline the IPR supervision intervention process:

1. *Setting the stage:* The supervisor introduces the IPR technique and process to the supervisee in a non-threatening way. In doing so, the supervisor may emphasize the reality that the depth and breadth of material in a counseling session is more than any counselor could ever attend to. Thus the purpose of IPR is for the supervisor and supervisee to work together to explore and reflect on potentially significant thoughts and feelings of the client and counselor during the session, including countertransference responses.
2. *Purposeful review and selection of recorded clinical material:* While playing the videotape, either the supervisor or supervisee can stop the recording when the occurrence of a “trigger event” is perceived. Trigger events are situations that are somehow upsetting, surprising, or confusing to the supervisee, client, or supervisor (Neufeldt, Karno, & Nelson, 1996). When applying IPR in supervision to address counselor countertransference responses, particular attention may be given to positive and negative countertransference behaviors (Friedman & Gelso, 2000), as well as objective and subjective (Kiesler, 2001) manifestations of this relational dynamic. Supervisor responses to countertransference-based trigger events can focus on the counselor’s skills and strategies, personhood, or clinical conceptualizations (Neufeldt et al., 1996), directing attention to not only what the supervisee is doing in session, but also to how the supervisee conceptualizes the client and therapeutic process, including the counselor’s contributions to this relationship.

3. *Discovery-oriented process questions and reflection:* Once identified, collaborative evaluation of the trigger event, including the counselor's existing cognitive frameworks for navigating the phenomenon begins. Through simultaneously supportive and challenging iterative questioning and reflection processes, more complex perspectives of previously unnoticed in-session events can be achieved. Larsen et al. (2008) suggested the following key considerations for supervisors for phrasing discovery questions during the IPR process. First, questions should be phrased in the past tense, in order to foster reflection about what the counselor was experiencing in the here-and-now moment of the therapeutic session. Second, process should be emphasized over content. Finally, questions should be framed as concisely and succinctly as possible. As summarized by Cashwell (1994, p.8), reflective question leads that might be utilized by supervisors during the IPR intervention process include:

- What do you wish you had said to him or her?;
- How do you think he/she would have reacted if you said that?;
- What is the risk in saying what you wanted to say?;
- If you had the chance now, how might you tell the person what you were thinking/feeling?;
- Were there any other thoughts going through your mind?;
- How do you want the other person to perceive you?;
- What did you want to hear from him/her?;
- What do you think he/she wanted from you?

4. *Closure:* The IPR intervention process comes to a close after the supervisee has explored thoughts and feelings surrounding the identified trigger event to some resolution. Throughout the intervention, attention should also be given to the supervisee's verbal and nonverbal responses with sufficient space given to process any incongruence (Cashwell, 1994). More complex, transformed conceptualizations of counselor countertransference responses and behaviors are sought, which may empower the supervisee to more readily understand, recognize, and navigate these trigger events in the future.

Case Example

Baxter is a second-year master's student receiving supervision during her internship in couples and family counseling. Throughout her clinical training sequence, Baxter has displayed moderate competence in assisting clients in identifying treatment goals, as well as in selecting and implementing treatment interventions. However, Baxter often expresses feeling "stuck" after a few sessions with client families. From the perspective of her supervisor, Baxter's feelings of being "stuck" may stem from establishing superficial, over systemic, therapeutic goals and avoiding in-depth client engagement. When this issue has been broached in supervision in the past, Baxter tends to become defensive, as evidenced by an over-explanation of the session content and processes that the supervisor has missed within the specific video clip or by reaching the conclusion that the client must be ready for termination. She displays some insight about

her tendency to become defensive, but is unsure of how to engage differently with her supervisor or clients.

In considering how to best support and challenge Baxter within clinical supervision, the supervisor considers Baxter's meta-cognitive reflection capacities toward in-session content, with particular attention to session depth, counselor reflexivity, tolerance for ambiguity, and use of deliberate action (McAuliffe & Lovell, 2006). Baxter appears to display some limitations in each of these reflection areas, but also a mastery of basic therapeutic skills. Baxter also self-reports that all of her clients "like" her.

After consideration of both Baxter's working knowledge of counseling theory and technique and confirmation of her desire to achieve greater depth in her clinical sessions, IPR was deemed to be an appropriate supervision intervention. Specifically, based on the information reported by Baxter, the supervisor hypothesized the "stuck" phenomenon may be influenced by counselor countertransference responses. To set the stage for the IPR intervention (Step 1), the supervisor first carefully described the process and purpose of this supervision intervention. Developing a stance of collaborative inquiry was also emphasized, so that the supervisor and Baxter engaged in a mutual reflection process rather than taking individualized stances as teacher and learner.

After establishing the context for the IPR intervention, the next task was to purposefully review and select a significant segment of recorded clinical material for further exploration in the supervision session (Step 2). As the goal of the current IPR intervention was to examine potential counselor countertransference responses, clinical interactions potentially illustrative of this relational dynamic were emphasized. Toward this, during the video replay a "trigger event" was identified by Baxter wherein a shift occurred in session as the client family discussed grief over the recent loss of a grandparent. After only a few minutes of this dialogue, Baxter noticed that she redirected the client to consider family strengths and positive memories. This moment was identified as a significant trigger event, as it appeared to elicit some confusion from both the counselor and client surrounding this abrupt shift in session tone and direction.

After stopping the video replay, a dialogical exchange of discovery-oriented process questions and reflection was initiated (Step 3). The supervisor asked Baxter to reflect on her here-and-now reactions to watching the video. She immediately confirmed that moment illustrated her consistent feelings of "stuckness" with clients. Baxter then discussed her thought processes underlying this in-session shift in tone and topic. Her clinical rationale included wanting to highlight family strengths, but also recognition of the discomfort she experienced in-session. Baxter stated she felt compelled to rescue herself and her clients from this pain and ambiguity of this moment.

In further exploring this moment as a countertransference response, the supervisor asked Baxter to consider what she wished she had said instead, how she imagined the client family might have reacted had she said this, and the risks inherent in doing or not doing this. Through a collaborative succession of discovery-oriented process questions, Baxter reflected on discomfort she had experienced following the death of her own grandmother. During this time, she felt cast as the family member responsible for maintaining hope and resilience, a family role she frequently found herself in. Baxter reflected that she had never fully processed the grief from her own loss and therefore, felt uncomfortable facilitating this process with another family. However, she acknowledged that emotional expression of the family's grief could be therapeutically beneficial and she

established confronting this topic and more effectively managing her feelings around loss as a personal goal for their next session.

At the close of the IPR intervention (Step 4), Baxter commented on the process with her supervisor. She stated their purposeful reflection on this trigger event poignantly illustrated a shift in the session tone and direction she had not previously noticed. Specific to her work with client families experiencing grief and loss, she reported feeling better equipped to recognize and reflect on her in-session engagements with clients. More generally, Baxter noted that while it was difficult at times, the IPR intervention helped forge a safe supervision environment for her to confront challenging clinical issues without feeling as defensive as she may have in the past.

Supervisor Considerations

Although IPR is a useful supervision technique for promoting self-awareness around counselor countertransference responses, it should not be used in isolation (Cashwell, 1994). Guided written reflections that offer additional space for supervisees to process the supervision intervention and to continue to formulate re-conceptualizations of trigger events are a useful follow-up activity. Without reflection, dissonance catalyzed by the IPR process may not transform to counselor developmental growth (Schmidt, McAdams, & Foster, 2009). Applied to the case example above, the supervisor may ask Baxter to respond to a written reflection prompt prior to the next supervision session. Prompts for the written reflection could explore Baxter's subjective responses to examining the potential impacts of her family roles or unresolved grief on her clinical work. A more general reflection on how Baxter may recognize and address other counselor countertransference responses in the future may also be warranted.

Feedback to guided written reflections requires careful and attenuated responses from the supervisor. Reiman (1999) outlined seven facilitative interactions between the individuals writing and responding to the guided reflections. These include: (a) accepting feelings, (b) praising or encouraging, (c) acknowledging or clarifying ideas, (d) prompting inquiry, (e) providing information, (f) giving direction, and (g) responding to problems. Based on patterns in the supervisee's written responses, the supervisor would respond in a developmentally matched context. For example, if Baxter was having difficulty discerning feelings, the supervisor may share feelings that serve as an example. As Baxter becomes more proficient in recognizing feelings, the supervisor may tend towards acceptance and exploration of feelings in the feedback provided.

In addition to monitoring for potential indicators of counselor countertransference, supervisors utilizing IPR interventions can consider counselors' developmental levels in structuring the application of this technique. Generally, counselors occupying lower developmental positions benefit from more structured, concrete, and directive learning contexts; counselors at higher levels are best suited to more collaborative and unstructured activities (Stoltenberg & McNeil, 2011). Additionally, counselors' conceptualizations of potential shifts in the supervision relational alliance should be considered, as a position of a "detached" inquirer is assumed in this activity, which may differ from typical supervisory interactions.

Conclusion

Establishing strong therapeutic alliances is essential to effective therapeutic outcomes. However, interpersonal relationship dynamics stemming from counselor countertransference responses may hinder the formation adequate therapeutic relationships. IPR is a supervisory intervention that can be utilized to bring attention to previously unnoticed, but significant clinical moments through intentional reflection on covert thoughts and feelings transpiring in-session. Through re-processing trigger events, counselor self-awareness and meta-cognitive reflection is enhanced. Consequently, counselors are supported in confronting interpersonal fears and countertransference and to maximize interpersonal dynamics toward clinical aims. Although IPR-based exploration carries some risk, ultimately counselors are assisted in establishing the meaningful and engaged therapeutic alliances necessary to positive therapeutic gains.

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