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Countertransference: Making the Unconscious Conscious

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OBJECTIVES

- Understand the nature and origins of countertransference
- Identify genetic counseling situations in which countertransference can occur
- Develop strategies for recognizing and managing countertransference

> *I think that countertransference is something that occurs constantly. What can change is our ability to recognize it (ideally at the time we are experiencing it) and work to return to "neutral" where we can accept this patient and their experience as unique, instead of playing into the countertransference dynamic.*
>
> Genetic counselor participant (Reeder et al. 2017, p. 941)

Genetic counseling is hard work. Along with aspects that are professionally and personally satisfying, and valued by the patient, the genetic counselor encounters challenges innate to human interaction – difficult circumstances and demanding interpersonal dynamics; complex decisions; strong emotions such as anger, elation, and anxiety; and varied cultural beliefs, values, and expectations. These challenges impact the genetic counselor, as well as the central component of genetic counseling processes and outcomes – the counselor–patient relationship, (McCarthy Veach et al. 2007). Countertransference is an inevitable side-effect (Reeder et al. 2017). Over time and in numerous ways, genetic counselors encounter many different experiences that potentially evoke countertransference (Abrams and Kessler 2002; Evans 2006; Reeder et al. 2017; Rolland 1994). Thus, it is essential that the genetic counselor be aware of countertransference and its' potential to aid, as well as interfere with, good practice and recognize the advantages of addressing it openly and knowledgeably (Abrams and Kessler 2002; Weil 2000a).

To promote awareness and discussion of countertransference, this chapter utilizes Gelso and Hayes (2007) five-component framework that includes countertransference origins, triggers, manifestations, effects, and

Genetic Counseling Practice: Advanced Concepts and Skills, Second Edition. Edited by Bonnie S. LeRoy, Patricia McCarthy Veach, and Nancy P. Callanan.

management strategies. Specifically, the chapter outlines the origins and triggers of countertransference, manifestation of countertransference by genetic counselors; and both positive and negative effects of countertransference on genetic counseling processes and outcomes. Strategies are then presented to help genetic counselors cultivate awareness and effective management of countertransference.

Definitions and Concepts

The term countertransference has roots in psychoanalytic psychology, where Freud described the psychoanalyst's unconscious emotional reactions to his or her interactions with the patient. It is important to acknowledge Freud's use of the related term *transference* to describe unconscious emotional responses on the part of the patient toward the psychotherapist (Weil 2000b). Thus, transference involves patient reactions *to* the therapist, whereas countertransference concerns therapist reactions *to* the patient.

In the elaboration of psychological theory and practice since Freud's time, the concept of countertransference has expanded. It is now understood to be an inevitable and potentially valuable aspect of clinical interactions, applicable to the work of other health care providers, including genetic counselors (Evans 2006; Weil 2000b). In genetic counseling, countertransference has been defined as conscious and unconscious emotions, fantasies, behaviors, perceptions, and psychological defenses the genetic counselor experiences as a response to any aspect of the genetic counseling situation. In other words, countertransference includes a broad range of conscious and unconscious emotions (both positive and negative) and psychological processes the counselor brings to his or her work and that the patient elicits. Particularly applicable to the short-term model of genetic counseling, authors in health care contexts such as emergency medicine have coined the term "instant countertransference" to describe the way in which countertransference can emerge in the shortest of interactions (Moukaddam et al. 2016).

Kessler (1992) describes two primary types of countertransference in genetic counseling:

1) *Projective identification*: The genetic counselor over-identifies with the patient and therefore mistakes their own feelings for those of the patient. While this form of countertransference may increase empathy if the counselor's feelings happen to match the patients, it can also result in the counselor mistakenly assuming they understand the patient's lived experience.
2) *Associative countertransference:* The genetic counselor becomes immersed in their own inner experience and as a result, focuses on themselves and not the patient. While associative countertransference may be triggered by similar feelings and experiences as projective identification, the counselor is often aware that their feelings/reactions are not those of their patients.

Reeder et al. (2017) noted aspects of both types of countertransference in their study of genetic counselor countertransference experiences in genetic counseling sessions. Factor analysis of their experiences suggested three countertransference themes: (i) *Control*: The counselor desired to control or influence either the uncertainty or the emotions present in a session; (ii) *Conflict Avoidance*: The counselor wished to prevent conflict by avoiding difficult emotions or decisions*;* and (iii) *Directiveness:* The counselor attempted to "push" patients into decisions commensurate with the counselor's views/beliefs or timeframe. While Reeder et al. acknowledged there may be additional tendencies, these themes provide initial guidance for genetic counselors and supervisors in assessing countertransference reactions.

The Countertransference Process

Reeder et al. (2017) documented the occurrence of countertransference in genetic counseling, and they identified themes consistent with Gelso and Hayes's (2007) countertransference framework. These themes (origins, triggers, manifestations, effects, and management) are presented next to more comprehensively describe the countertransference process.

Origins of Countertransference

Countertransference is a universal phenomenon in genetic counseling, often grounded to a significant degree in the genetic counselor's previous experience (Hyatt 2012; Likhite 2000; Mathiesen 2012; Peters et al. 2004; Reeder et al. 2017; Woo 2002). Prior to discussing its impact on clinical work, an understanding of the various life experiences that contribute to countertransference is essential. Six general categories of life experiences comprise potential sources of genetic counselor countertransference: family dynamics, developmental life processes, life vulnerabilities, cultural background, professional training and socialization, and contemporary issues.

Family Dynamics

Countertransference is often a response to a genetic counseling patient/situation that evokes conscious or unconscious reminders of significant, experiences in childhood (Hayes and Gelso 2001). Genetic counseling interactions can evoke memories and responses from the genetic counselor's childhood experiences; for example, a needy or depressed parent who pulled for support from the child, an overprotective parent who did not provide adequate opportunity for the child to experiment and grow, or a parent who became uncomfortable or upset if the child expressed strong emotions. Other early interactions that may eventually evoke countertransference include those that more clearly involve the child's role in the family structure. For example, an oldest child who had significant caretaking responsibilities for younger siblings may develop strong positive and negative associations with that role when a patient evokes it during a genetic counseling session (Schneider et al. 2000). As another example, a child who was caught between feuding parents (i.e. triangulation, see Weil 2000b) may develop strong responses to contentious interactions between members of a couple in prenatal counseling or to discord between parents of an affected child (Weil 2000b). Thus, countertransference may occur in response to an individual patient, couples, and families.

Developmental Life Processes

Although childhood interactions, primarily within the family, have a major role in countertransference, experiences throughout the life cycle also contribute. Adolescence presents new challenges involving independence, peer interactions, sexual maturation and identity, and interactions with the larger world (Weil 2000b). For example, if a genetic counselor has had a difficult time achieving independence from the nuclear family or has had difficult interactions with authority figures such as teachers, these experiences may influence reactions to later interactions involving patient issues of independence and autonomy.

Sexual and romantic experiences, marriage, marital discord and divorce all have the potential to significantly affect a genetic counselor's subsequent reactions. For example, a recently married genetic

counselor may find themselves unable to tolerate disagreements between a couple trying to decide about prenatal testing. They may distance themselves from engaging the couple in a needed discussion about their differing perspectives given their own fear or worry of what challenges their marriage may face in the future. Parenting presents new experiences and challenges that can profoundly influence the genetic counselor's sense of self and of loving and caring for another person that may change their perspective on parent's coping and adjusting to a genetic diagnosis in themselves or child(ren). Parents often encounter challenges concerning their adolescent child(ren) as well, and these experiences may influence how the genetic counselor responds to adolescent patients who are pregnant or have a disability, including issues of dependence and independence, and sexual experience and identity (Hayes and Gelso 2001; Weil 2000b).

Life Vulnerabilities

Throughout life, genetic counselors confront injury and loss through personal experiences, those of family and friends, and reports in the larger world that often involve natural and human-caused catastrophes. Issues of physical and mental disability also confront the genetic counselor, either within the family or as experienced with peers or in other social encounters and interactions. From these experiences of vulnerability, the genetic counselor develops differing beliefs, values, coping mechanisms, and feelings about the meaning of life, illness, disability, suffering, and death. Genetic counselor values inevitably influence their behaviors – either consciously or unconsciously. Pirzadeh and colleagues (2007) found genetic counselors highly valued benevolence, self-direction, achievement, and universalism; thus, genetic counselors value social responsibility and desire to help others. Recognizing the source(s) of one's values and their potential impact is important given their influence on genetic counselor behaviors (McCarthy Veach et al. 2018).

Life experiences also influence beliefs, attitudes and feelings about medical care and health care practitioners. An illness or death of a parent during childhood, adolescence or adulthood; the loss of a pregnancy or birth of a child with a disability; and personal disability or chronic illness can profoundly affect a genetic counselor's responses to the issues that arise in genetic counseling (Anonymous 2008; Bellcross 2012; Clark 2010, 2012; Keilman 2002; Kessler 1992; Rolland 1994). Hodgson and Weil (2012) examined how prenatal genetic counselors discuss disability with patients. They noted how counselors' preconceived biases and beliefs about life with a disability may impact their genetic counseling, specifically information they provide about conditions such as Down syndrome, both in a positive and negative light. Their participants expressed a desire to engage in reflection and self-assessment as a means to evaluate how vulnerabilities throughout their life concerning disability influence their counseling.

Cultural Background

Ethnicity, culture, religion, sexual orientation, socioeconomic status, and disability are forms of diversity worth examination given the potential for misunderstanding and conflict. No matter how accepting and understanding genetic counselors may be personally, overt and subtle societal influences as well as direct experience at different times in life may lead to misunderstanding, insensitivity, and stereotyping of individuals whose history, culture, and circumstances differ from their own. A genetic counselor's social identities (e.g. gender, race/ethnicity, sexual orientation, religious, and political beliefs) subtly affect the counselor–patient relationship, both in instances of recognized and unrecognized difference (Smith and

Tang 2006). For example, countertransference may emerge when a patient's cultural views of nature and origins of illness differ from the genetic counselor's medical–genetic explanation (Sayed 2003). The counselor's desire to have their own identity (in this case, their identity as a genetics expert) known can result in powerful countertransference reactions. Stampley and Slaght (2004) interviewed social worker clinicians about their work with clients from diverse backgrounds and found the clinicians' family beliefs and messages, societal and environmental influences, and their personal life experiences influenced their cultural countertransference.

Countertransference concerning diversity can also result from what the genetic counselor does not know and has not experienced about another person's life. This may include a failure to recognize real and perceived differences in power and control between the genetic counselor and patients from groups that have experienced discrimination and repression, as well as a failure to understand the significance of current and historical prejudice, discrimination, oppression, and violence as they have affected the patient (Lewis 2002; Sue et al. 2019; Warren n.d.).

Professional Training and Socialization

Individuals usually choose and enter the genetic counseling profession with a desire to be helpful to others, to be professionally and clinically successful, and often with a wish to combine their strong interest in science or genetics with an equally strong desire to work with people. These beliefs and values develop further during education and training and then through experience as a practicing genetic counselor (Miranda et al. 2016; Runyon et al. 2010; Zahm et al. 2008; Zahm et al. 2016). Although a wide variety of professional training and socialization issues can contribute to genetic counselors' countertransference, common themes include:

- a desire to be helpful and effective even in circumstances where the genetic counselor's ability to affect the outcome may be limited (Evans 2006; Hiller and Rosenfield 2000)
- issues related to professional competence and to interactions with individuals in positions of greater and lesser authority than that of the genetic counselor (Weil 2000b)
- application of genetics and Western medicine information and technology to a range of human conditions in which the patient may have a different or broader view of the nature, causes, and potential means of prevention or alleviation (Shaw and Hurst 2008)

Contemporary Issues

Personal or family difficulties that occur while the genetic counselor is working have an immediate impact. This is especially true of losses or bereavement similar to the types of situations that occur for patients – infertility, fetal loss, or the birth or diagnosis of a child with a disability; marital discord, separation, or divorce; personal illness or disability; and the death of a family member or close friend (Weil 2000b). When genetic counselors recently or currently experience a situation of this type, their ongoing grieving process may interfere with their ability to maintain appropriate emotional distance interacting with a patient with related concerns (cf. Anonymous 2008). Emotions such as grief, anger, or hopelessness, and psychological defenses such as partial denial early in the grief process – all of which may be normal and adaptive – may make it difficult for the genetic counselor to distinguish those aspects of the counseling process that belong to the patient and those that belong to the genetic counselor (Evans 2006; Kessler 1992; Mathiesen 2012).

Countertransference Triggers

While *origins* set the specific contexts in which countertransference can emerge, it is important to recognize circumstances that commonly evoke countertransference. Countertransference triggers can involve patient characteristics and situations, either alone or in combination with the counselor's prior or current circumstances. Four general types of circumstances are particularly common: patient characteristics; disease, disability, and loss; diversity issues; and challenging genetic counseling situations.

Patient Characteristics

Individual patient characteristics may evoke strong emotions in the genetic counselor, either conscious or unconscious. Reeder et al. (2017) identified similarities, both demographic similarities and "general similarity," as well as medical/genetic similarities between the patient and genetic counselor as triggering countertransference reactions. A patient's appearance and/or behavior may evoke a response by reviving a memory of an important individual from the genetic counselor's past. These characteristics can range from obvious similarities to subtle aspects that are beneath consciousness. For example, the genetic counselor might feel that:

- "She's being bossy, and it feels like what my mother did when she was upset."
- "Her smile reminds me of my third-grade teacher, whom I liked so much."

A patient's emotional responses may evoke strong countertransference. For example, anger, despair, and hopelessness can be difficult to confront, either because they evoke an empathic response in the genetic counselor (e.g. projective identification where the genetic counselor also feels a sense of hopelessness) or because they evoke responses from earlier in life (e.g. the genetic counselor feels anxious, as she did when her father felt hopeless during a long period of unemployment). Schema and colleagues (Schema et al. 2015) found that a majority of genetic counselor participants had experienced patient anger, and this anger impacted how they managed the session, especially when counselors took the anger personally. Reeder et al.'s (2017) genetic counselor participants also reported anger as a trigger for countertransference.

The patient's use of defenses (e.g. denial, deferral, excessive information-seeking) may also lead to countertransference. Again, this may be because the defense mirrors an aspect of the genetic counselor's previous experience ("He shifted away from what he was feeling and starting talking about facts, just like my dad used to do when I tried to find out where things stood between us"). Alternatively, a patient's psychological defense may be similar to one the genetic counselor commonly uses, which can lead to a mutual continuation or escalation of the defense within the session, as the following example illustrates (Weil 2000b, p. 88):

> A young adult experiencing mounting anxiety about a diagnosis of spinal muscular atrophy began joking about difficulties he had encountered while trying to find the genetics clinic in the medical building complex. The genetic counselor, who was feeling a growing sense of sadness for this personable, athletic young man, joined in the joking. It was only when her discomfort at the avoidance of substantive discussion became conscious that she realized her collusion in the defensive humor, and she gently returned the discussion to how the young man thought he might cope with the early stages of the disease.

Psychological defenses can also add a layer of complexity to the genetic counselor's attempts to understand and empathize with the patient, as the following pair of examples illustrate:

> An adolescent single mother appeared very hopeless after she discussed her baby's relatively minor disability with the genetic counselor. The counselor also felt some hopelessness. Upon reflection, he realized it was an empathic response to the mother's circumstances and feelings. This realization helped to lift his own sense of hopelessness and allowed him to focus on exploring the various supports available to the mother. Together, they identified several, and the mother's hopelessness declined appreciably.

A few weeks later, a 34-year-old married mother became quite hopeless when informed that her baby had a similar disability [to the earlier the baby with a minor disability of the adolescent mother]. Based on his previous experience and self-reflection, the genetic counselor more quickly recognized and moved past a transient feeling of hopelessness to again explore available supports. Although they identified substantial family, social, and financial resources, the mother remained quite hopeless. The genetic counselor began to feel annoyed, especially in light of the patient's resources. He recognized that his reactions were due in part to a feeling of professional failure (see below). He had more difficulty moving beyond this feeling, but he was able to "set it aside" in order to inquire about the mother's beliefs about why her child was affected. With careful exploration, the counselor discerned that the patient's hopelessness was a defense against her guilt about having consumed a number of drinks at a party during her second trimester. The patient's unconscious process was: "If the situation is hopeless, there is nothing I could have done to change it, so there is no reason to feel guilty." Once they addressed her feeling of guilt, the patient's mood improved, and her usual sense of confidence reappeared. As with the previous patient, the genetic counselor was able to work effectively with her, but with considerably more complex and pervasive countertransference in response to this patient's unconscious psychological defense.

These examples not only illustrate the counselor's empathy for the patient's hopelessness, they also demonstrate the way in which countertransference can inform a counselor's empathy in a potentially beneficial manner. Had the counselor not "listened" to his annoyance and set it aside, he would have been unable to address the patient's guilt and instill a sense of confidence.

Interactions between patients and family/significant others during a session, or patients' reports of interactions with others outside the session, can also evoke strong countertransference, as the following example illustrates:

> A married couple disagreed about whether to have amniocentesis following a prenatal screen-positive result. The husband was subtly dismissive of the wife's concerns about miscarriage in a way that was a painful reminder for the genetic counselor of interactions between her parents when she was a child. The genetic counselor recognized her memories and emotions early in the session but only later realized she was siding, subtly, and angrily, with the wife. Combining awareness of her behavior with awareness of its origins, she altered her approach. She took a more balanced approach to the husband and wife and was more effective in giving the wife an opportunity to describe her feelings and concerns to the husband.

Disease, Disability, and Loss

In the course of their work, genetic counselors repeatedly face patient situations involving disease, disability, and loss in the form of intellectual disability, physical disability, chronic illness, genetic disorders, infertility, fetal loss, and death (McCarthy Veach and Leroy 2012). In addition to countertransference based on the genetic counselor's previous experience (e.g. a parent's disability, a personal fetal loss) these

situations may also evoke anxiety or fear about current or future vulnerability (Reeder et al. 2017). For example, a genetic counselor who has recently begun discussing a first pregnancy with her husband may find it difficult to avoid emotionally distancing herself in a session involving fetal loss. Alternatively, she may maintain full emotional engagement but find her attention drifting from the patient's concerns to the question, "What will I do if I find myself in a similar situation?"

A single genetic counseling case may evoke substantial countertransference, as may a sequence of challenging, complex cases. The genetic counselor's own emotional resources and self-awareness affect the manner and extent to which these encounters evoke countertransference. Patient responses to these circumstances also are influential. Genetic counselors generally find it easier to encounter patient resilience, planning and overt expression of emotions than anger, hopelessness and avoidance or denial.

Patient Diversity

Working with patients who differ from the genetic counselor with respect to ethnicity, culture, religion, sexual orientation, socioeconomic status and/or disability may raise issues of countertransference (Nathan et al. 2018; Sayed 2003; Smith and Tang 2006; Stampley and Slaght 2004). These cultural differences have been found to influence the genetic counseling session, whether in the working alliance, implicit patient preferences, the information provided in the session or patient's perception of the clinical interaction (Nathan et al. 2018; VandenLangenberg et al. 2012).

Stereotypes, fears, misunderstanding, or misinterpretation may occur when the genetic counselor confronts a situation in which, to a greater or lesser extent, his or her own background and experience provide less of a guide for understanding the patient's beliefs, values, expectations, and responses. The genetic counselor may feel anxious and begin to doubt her or his professional competence. Some counselors may feel guilt or anger based on their knowledge and experience of institutional racism and other forms of institutionalized discrimination and prejudice. For some, guilt may also occur based on their awareness of relative privilege compared to the patient (Weil 2000b).

The patient's beliefs, values, and expectations may challenge those of the genetic counselor. These challenges may be related to alternative health beliefs and practices, including doubt about the efficacy of Western medicine; the role of family members in health care and decision making; the dominance of husband, father, or other family member over a woman's reproductive decisions, health care and/or communication during the genetic counseling session; and the social role of consanguinity, especially when there are multiple children affected with an autosomal recessive disorder (Sayed 2003; Stampley and Slaght 2004). The genetic counselor may feel anxious, uncertain, defensive, and/or angry. These responses can intensify due to language barriers or when the patient responds with rejection, withdrawal, or non-compliance. The genetic counselor may also encounter patient mistrust and anger due to historical and current experiences of oppression and discrimination, either in general, or by social agencies and/or the medical establishment (Sue et al. 2019; Weil 2000b).

Challenging Genetic Counseling Situations

Certain aspects of genetic counseling may be particularly likely to induce countertransference for many genetic counselors. These include, but are not limited to:

Giving bad news requires the genetic counselor to process the information ahead of time, plan how to present it, anticipate how the patient may react, and then remain emotionally available and empathic as the patient responds, under circumstances where there is little or nothing the genetic counselor can do to alleviate the situation (Reeder et al. 2017).

Genetic counseling with children and adolescents raises countertransference issues such as the vulnerability of children and their embeddedness within the family, and adolescent issues of independence vs. dependence, sexuality, social development, and pregnancy. As mentioned earlier, countertransference may arise from the genetic counselor's own earlier life experiences or those related to raising children (Weil 2000b).

Genetic counseling for cancer or neurogenetic disorders involves common diseases for which issues of vulnerability and personal or family loss may be evoked, either by knowledge and publicity concerning their prevalence, or from personal and/or family experience (Schneider 2002). For example, after discussing family risk for Alzheimer's disease with several patients, the genetic counselor may feel preoccupied and anxious about the implications for his or her aging parent's recent behavior.

Ethical dilemmas may raise countertransference issues. There is a long, complex relationship between clinical genetics and genetic counseling and the issue of disabilities. However much the genetic counselor may strive to provide balanced information and support a range of options, aspects of prenatal screening and diagnosis implicitly or explicitly imply that termination is the appropriate or desirable response to a fetus with a major genetic disorder or disability (Rapp 1993). Beyond the difficult and complex issue of how to identify and provide "balanced" information, members of the disability right's movement have actively challenged the ethical propriety of prenatal diagnosis and selective termination (Farrelly et al. 2012; Madeo et al. 2011; Ormond et al. 2003; Parens and Asch 2000; Parens and Asch 2003). These issues can create practical and ethical dilemmas that, if not adequately examined, lead to countertransference.

Suicide by patients and former patients is presumably rare (Peters 1994). Nevertheless, as in other forms of health care, when it occurs, it requires immediate intervention to address the emotional reactions and countertransference of the genetic counselor and other affected staff. Reactions may include shock, grief, and recurrent or obsessive thoughts concerning actions that, realistically or unrealistically, might have prevented the suicide (Bosco 2000).

Finally, when the genetic counselor confronts a *current personal issue of disability, trauma or loss,* including those involving health, relationships, marriage, or family, the related issues involved in providing genetic counseling services assume special significance with respect to countertransference (McCarthy Veach et al. 2018; Weil 2000b).

Manifestations and Effects of Countertransference

While countertransference is an inevitable dynamic in genetic counseling (Reeder et al. 2017), how it manifests and its' effects on the session can vary. In simple terms, the impact of countertransference can be adaptive, maladaptive or both:

- *Adaptive* – for example, based on experience with her or his parent when young, the genetic counselor is sensitive to subtle cues that a patient is becoming angry
- *Maladaptive* – for example, based on how he or she responded to the angry parent when young, the genetic counselor may withdraw emotionally.
- *Both adaptive and maladaptive* – for example, the genetic counselor realizes the patient is becoming angry, feels some sense of emotional withdrawal, but responds to the patient with understanding and empathy

The key distinction between an adaptive or maladaptive response to countertransference is recognition and self-awareness. Self-awareness regarding countertransference can vary in several ways. The genetic counselor may be unconscious of a particular issue, vaguely aware of it, or quite cognizant.

Assuming some degree of awareness, the genetic counselor may experience the feelings or thoughts as an unexamined part of the self, recognize them as a matter worthy of attention, or have explored the origins and consequences in some detail. Likewise, the genetic counselor's awareness of the circumstance(s) that give rise to the response may vary from little or none to a great deal.

Genetic counselors can also pay attention to behaviors that indicate potential countertransference. Hoffsess and Tracey (2010) discussed a range of therapist behaviors that may signal countertransference (as summarized in McCarthy Veach et al. 2018):

- Overprotection of client by shying away from difficult informational content (prognosis, symptoms)
- Loss of neutrality and siding with patient
- Engages in more self-disclosure than is typical
- Feels like fixing or solving patient's problems
- Experiences strong negative (anger, frustration, apathy) or positive (elation, hope, relief) in working with client

It is useful for purposes of discussion to distinguish two broad endpoints: countertransference issues the genetic counselor has not examined, and those he or she has examined with substantial thought and insight. As discussed, each endpoint results in a different impact on the genetic counseling session.

Unexamined Issues

Unconscious countertransference is clearly beyond the control of the genetic counselor and thus, may negatively affect interactions with patients. Optimally, counselors can anticipate potential countertransference issues as part of their ethical obligation to adequately identify and understand them (Kessler 1992). While not exhaustive, some issues that may unconsciously evoke countertransference are discussed next.

The Genetic Counselor's Emotional Responses to the Patient

Genetic counselors routinely face a wide variety of patient feelings, thoughts, and behaviors that naturally evoke the genetic counselor's emotions. Common counselor reactions include anger, frustration, disapproval, annoyance, guilt, boredom, sadness, a sense of inadequacy, and feelings of nurturance. If unexamined or unconscious, these emotions can result in overt expression or be revealed subtly through the counselor's body language (Hayes and Gelso 2001; Hayes et al. 2011; Likhite 2000; Peters et al. 2004). The consequences of such emotions can extend beyond behavioral manifestations, however. They can interfere with the genetic counselor's perceptions and assessment of the patient's beliefs, values and circumstances. As discussed, these feelings may also impair the genetic counselor's capacity for empathy in maladaptive countertransference. If sufficiently intense and uncomfortable, or if the genetic counselor tends to avoid unpleasant emotions and situations, he or she may limit discussion and exploration of certain topics. More broadly, the genetic counselor may withdraw emotionally from the interaction, prematurely terminate a discussion or session, and/or provide inadequate follow-up (Kessler 1992; Nathan et al. 2018; VandenLangenberg et al. 2012).

For example, in response to an angry patient's dismissal of the genetic counselor themselves or information presented, the genetic counselor may occasionally become rejecting or hostile. However, not all emotional responses are of a limiting or distancing nature. Feelings such as sadness, frustration,

and guilt may lead the genetic counselor to become overly involved, with inappropriate attempts at nurturance, directiveness, and involvement in patients' issues (Hayes and Gelso 2001; McCarthy Veach et al. 2018).

Identification with the Patient

Understanding the patient and drawing on one's own relevant experience are essential to empathic, effective genetic counseling. However, this feeling of identification, especially over-identification with the patient, can also result in ineffective and inappropriate countertransferential responses. At one end of the continuum, the genetic counselor may feel an unrealistic sense of understanding or identity with the patient given personal similarities such as age, marital status, or more specific personal characteristics (Smith and Tang 2006). Countertransference may also occur when the genetic counselor has had a personal experience relevant to the patient's genetic counseling issue such as prenatal diagnosis, fetal loss, having an affected child, and a personal or family experience of cancer (Anonymous 2008; Bellcross 2012; Glessner 2012; Hyatt 2012; Keilman 2002; Kinsley 2012).

Based on this sense of identification, the genetic counselor may overestimate his or her level of understanding of the patient's situation and experiences. As Kessler (1992) points out, "invariably there are always subtle differences in family dynamics, life history, etc." (p. 305). Over-identification may lead to inadequate discussion and exploration of the patient's concerns and circumstances, because the genetic counselor believes she or he understands those matters adequately (Nathan et al. 2018; VandenLangenberg et al. 2012). As a participant in Reeder et al. (2017) stated, "I am sure each time I rushed onward, preventing the opportunity for the patients to talk about their miscarriages" (p. 941). Over-identification may cause the genetic counselor to become directive, out of a sense that his or her parallel experience provides an appropriate guide for how the patient should think about and/or address the situation. Alternatively, the genetic counselor may withdraw emotionally or terminate discussion prematurely when the emotional issues the situation raises for him or her are too threatening (Reeder et al. 2017).

Over-identification is an example of Kessler's (1992) projective countertransference, a complex process that may lead to the mistaken belief that the counselor's feelings are the patient's feelings (Evans 2006; Kessler 1992; Peters et al. 2004). As Kessler (1992) says, "[W]e can never really know or understand another's suffering" and, "[W]e lose our sense of whose discomfort is being managed in our intervention, the client's or our own. We have projected our thoughts and feelings and made them our own" (p. 305).

Likhite (2000) presents an extended discussion of a case of associative identification. The patient, who had been the victim of a vicious assault as a teenager and of later domestic abuse, took on the role of victim when offered fragile X prenatal testing based on family history and again when her fetus was identified as having a full mutation. During the complex interactions between patient and genetic counselor, the counselor developed a sense of being the victimizer. This led to feelings of annoyance and guilt and to difficulty providing empathic counseling. This case required thoughtful personal insight and peer supervision in order for the genetic counselor to understand the powerful role her countertransference was playing in her interactions with this patient.

Boundary Issues

Some countertransference dynamics can lead to a loosening or breakdown of appropriate boundaries with the patient (Reeder et al. 2017). Patients who are very needy, appear helpless, or are in challenging

circumstances may evoke the genetic counselor's desire to respond with friendship, assistance with practical matters and repeated reassurance beyond what is appropriate to the genetic counseling relationship. An example is the patient who repeatedly calls the genetic counselor while waiting for test results. When the calls extend beyond an appropriate request for help dealing with anxiety or for reassurance that the results are not yet available, the patient may be attempting to establish a personal friendship or obtain help dealing with other life problems. The patient can evoke countertransference feelings of professional inadequacy or guilt. They may also play upon the genetic counselor's more habitual tendencies toward nurturance and a desire to avoid disappointing others (Weil 2000b).

Appropriate boundaries are also weakened when the genetic counselor adopts or facilitates the patient's psychological defenses. As the above example of the patient with spinal muscular atrophy illustrates, a patient may use humor as a defense against anxiety or hopelessness, or to avoid meaningful discussion of painful issues. If the genetic counselor feels anxious about the patient's circumstances or process, and humor is among his or her common defenses, the counselor may collude with the patient in extending humor beyond appropriate limits (Weil 2000b).

Genetic counselor personal self-disclosure constitutes a particularly important boundary issue (Redlinger-Grosse et al. 2013). Self-disclosure can involve, for example, sharing of similarities in life circumstances, reproductive history, or experience with a procedure or circumstance that the patient confronts. While self-disclosure can convey empathy and understanding, there are potential drawbacks. It may shift the focus from the patient to the genetic counselor and/or lead to unrealistic expectations of friendship, help, and continued interactions with the counselor outside the genetic counseling framework. Thus, it is imperative that genetic counselors use self-disclosure sparingly and strategically, in order to avoid disclosure triggered by countertransference (Balcom et al. 2013; Kessler 1992; Peters et al. 2004; Redlinger-Grosse et al. 2013; Thomas et al. 2006; Weil 2000b). Two important questions counselors should ask themselves are, "How will my self-disclosure benefit the patient?" and "Can I achieve the desired goal with a different type of response?" (Thomas et al. 2006).

Impact of Countertransference on the Genetic Counselor

A genetic counselor will encounter a single case or a series of cases that evoke countertransference, with its' inevitable personal effects (Reeder et al. 2017). Countertransference, especially when unmanaged, may result in residual feelings of frustration, sadness, anger, professional inadequacy, and unfulfilled desires to be helpful or nurturing. Evans (2006, p. 157) speaks to this issue as follows:

All counselors are at risk of being disturbed at some point or another and they may experience physical sensations or feelings. Headaches, tiredness, or being depleted or stressed are common physical complaints; depression, anxiety, or feeling unexpectedly angry [are] common emotional reactions. These feelings and sensations are unpleasant but can be understood, alleviated, or even prevented by a deeper understanding of the delicate, interactional processes by which individuals affect one another. This involves addressing countertransference issues.

Examined Issues

Adequate examination of a countertransference issue greatly reduces the likelihood that it will lead to an inappropriate or counterproductive action or response. To the extent that the genetic counselor is conscious

of the issue, its' origins and triggers, she or he can use the countertransference as a source of valuable information, insight and empathy (Evans 2006; Hayes et al. 2011; Weil 2000b). A central aspect of examined countertransference is the ability to identify the source(s) of a response and use the information appropriately. As Weil (2000b) states, "When one can, with reasonable reliability, identify one's own countertransference issues, one's emotional responses to the counselee have greater value and trustworthiness as a guide to clinical work" (p. 91).

Emotions that are Not Based on Countertransference

It is important to determine whether an emotional reaction is, in fact, countertransference or a "normal" response to a situation (McCarthy Veach et al. 2018). Feeling sad about a patient's diagnosis, annoyance at a patient who arrives very late, or wishing one could help a patient who is socially isolated are normal feelings in the clinical setting, as they would be in other circumstances. In these examples, if the genetic counselor has examined her or his personal issues regarding anger, failure to comply with expectations, and the pain of social isolation, the counselor can experience the emotional aspects of the situation more receptively, less defensively, and thus with greater empathy.

Emotions Arising Primarily from the Genetic Counselor's Experience

When a situation evokes countertransference around issues that have been examined, the genetic counselor's emotions, associations, and sensitivities are valuable guides. Under these circumstances, recognizing the similarities between one's own experience and that of the patient can provide useful guidance about the patient's fears, concerns and need for information (Keilman 2002; McCarthy Veach et al. 2018).

Examined issues also contribute to the genetic counselor's awareness of pending complexities and difficulties in the clinical interaction. For example, a genetic counselor who, as a child, developed watchful sensitivity to his mother's frightening anger, may anticipate a patient's repressed or developing anger long before it would be apparent to someone who had not identified and examined such a countertransference issue. Again, the fact that the issue has been examined allows the genetic counselor to confidently use his or her rising anxiety, alertness, and specific interpretation as helpful information about the patient.

Emotional Responses to the Patient's Mood or Behavior

The genetic counselor's reactions to the patient's mood or behavior provide valuable information and guidance. When, for example, a patient is sad, hopeless or needy, feelings of nurturance and a desire to help may be evoked. While this can enhance the genetic counselor's empathy, it may be helpful for the counselor to examine whether this emotional response to the patient may indicate a larger, universal relational pattern. Do other people in the patient's life get pulled to nurture rather than empower this patient? Ultimately, the counselor may help the patient gain insight into unrecognized thoughts, emotions, and/or behaviors when shared through advanced empathy statements (McCarthy Veach et al. 2018). A genetic counselor's advanced empathy responses provide potentially valuable insight into how the patient feels about him or herself and how she or he interacts with others (Evans 2006; Weil 2000b). A counselor's insights may also motivate her or him to take useful additional steps, such as assisting with a referral for social services.

Management of Countertransference

As the preceding discussion indicates, identifying and examining countertransference reduces the likelihood that it will lead to ineffective or inappropriate interventions and enhances its value as a source of empathy and a guide to effective interventions (Reeder et al. 2017). As a first step, it is important that the genetic counselor accept that countertransference is a normal, inevitable aspect of human interactions (Evans 2006; McCarthy Veach et al. 2018). This does not mean that addressing it is necessarily easy or free of emotional distress. Experiences that contributed to countertransference may be difficult and painful to contemplate and analyze. In addition, the emotions, behaviors, and defenses involved in countertransference may fall short of the genetic counselor's desired personal, social, and professional self-image.

Due to the habitual, potentially painful, and frequently forgotten or repressed aspects of countertransference, there are limits to what individuals can identify and explore adequately by themselves. For these reasons, assistance from others is often necessary to address the most longstanding and/or emotion-laden aspects of countertransference. As Moukaddam et al. (2016) state, "no manual can prepare us fully for patients who reject our help, tug on our heartstrings, revive our deepest memories, or elicit fear, pity, or shock or disbelief" (p. 1). Thus, finding outlets to increase self-awareness, both individually and with others, is necessary for effective management of countertransference (Bernhardt et al. 2010; Peters et al. 2004; Pirzadeh et al. 2007; Reeder et al. 2017).

Individual Approaches

As a starting point to recognizing countertransference, there are several complementary approaches through which genetic counselors can address their own origins and triggers of countertransference.

Recognizing One's Emotions and Behavior

An important first step is to give thoughtful, non-defensive attention to the feelings that occur before, during and after a clinical session as well as behaviors that occurred during the encounter (Abrams and Kessler 2002). The types of emotions and their intensity and frequency are relevant. Mindfulness of one's emotions – both negative and positive – can serve as a "SOS" to indicate the need for further attention (Bernhardt et al. 2010; Silver et al. 2018). Anxiety may point to unrecognized countertransference issues – something is amiss, but one is not yet aware of the specific problem. Feelings such as anger, boredom, sadness, unfulfilled nurturing or professional inadequacy (beyond what seems like normal or expected) may indicate more specific countertransference issues (Hayes and Gelso 2001; Lee et al. 2015). Similarly, feeling a strong compulsion to give advice, having fantasies of being able to assist the patient when others have failed to do so, or disliking or avoiding emotional interaction with a patient are very suggestive of countertransference (McCarthy Veach et al. 2018). Having identified a pattern of emotions and behaviors, it is then important to locate their source in previous experiences as well as contemporary issues (see "Reviewing life experiences" below).

Counselors may benefit from guiding themselves in an intentional manner when reflecting on challenging cases. Reeder et al. (2017) outline three key questions a genetic counselor can ask in reflecting on potential countertransference experiences:

- What is (was) my reaction (feelings, thoughts, actions)?
- Why am I reacting (did I react) that way?
- Where did my reaction come from?

Counselors may also benefit from asking, Is my reaction coming from my life or my patient's life? (Scaturo 2005), and What are my expectations for the relationship with the patient, and are they realistic? (Bannink 2006).

Identifying Genetic Counseling Triggers

It is also important to identify those genetic counseling situations in which countertransferential emotions and behaviors potentially occur (Evans 2006; Kessler 1992; Reeder et al. 2017) including:

- Patient characteristics such as neediness, anger, need to control, emotional withdrawal or couple disagreement.
- Types of genetic counseling patients or disorders, such as adult onset disorders, cancer risk counseling or genetic counseling with adolescents.
- Specific activities such as giving bad news, facilitating pregnancy termination, or working with patients who have received screen-positive prenatal results given the very high rate of false positives.
- Ethnic, cultural or socioeconomic communities with whom providing genetic counseling raises anxiety, uncertainty, or difficulty understanding their values, expectations and decisions.
- Counselors can also begin to anticipate how their ability to tolerate (or not) difficult emotions may impact their genetic counseling work. The Tolerance for Negative Affective States (Bernstein and Brantz 2013) is a validated measure of an individual's tolerance for negative emotions such as anger, disgust, anxiety, sadness-depression, fear-distress, and negative social emotions. This self-report scale may serve as one way for genetic counselors to examine which negative patient emotions may be particularly challenging and subsequently evoke countertransference.

Reviewing Life Experiences

It is also beneficial for genetic counselors to review their life experiences and the emotional, behavioral and defensive responses that have developed. Review of these life experiences through a written "cultural autobiography" can provide an assessment of a counselor's background that may provide anticipation of countertransference (Stampley and Slaght 2004). A cultural biography includes (but is not limited to): family interactions in early childhood as well as peer and other social interactions during school age and adolescence; sexual/romantic development and relationships; work and education; professional training; experiences with and attitudes toward individuals with disabilities; and personal, family, and social environments in terms of experience, attitudes, stereotypes, and lack of information about individuals who differ with respect to ethnicity, culture, economic status, religion, and other relevant characteristics. A cultural autobiography also includes the genetic counselor's personal and family experiences with health and illness, disability, and death (Evans 2006; Rolland 1994).

It is equally important to consider current issues that might affect clinical work (Evans 2006; Rolland 1994; Weil 2000b). These include illness and health issues of the genetic counselor and his or her family or close friends; couple or marital issues; recent or emotionally unresolved deaths; and issues such as a partner's loss of employment that might increase one's sense of vulnerability concerning competence

and security in the workplace. Positive experiences may also be important. Marriage, the birth of a child, or a child leaving home for work or school can provide strong positive feelings that carry over into the workplace. The genetic counselor should consider who provided love, support, encouragement, protection, and assistance as well as what was difficult, frightening and caused pain or suffering in each of these situations. Central to such a review is looking at the ways in which the experiences and how one responded at the time carry over into current responses to patients and their experiences (Reeder et al. 2017).

Synthesizing One's Approaches

These three individual approaches provide a basis for identifying countertransference that occurs in response to particular stimuli and how it may be related to previous and/or current experience. In reality, these approaches may overlap, and the lines of recognition and analysis can run in any direction. For example, the genetic counselor may be aware that his father's severe illness when the genetic counselor was young has influenced his feelings about working with adult onset disorders. From this awareness, he may then proceed to a more detailed understanding that he becomes anxious and irritable when patients do not follow recommendations that might help alleviate the severity of their symptoms. This reaction then leads to ineffective attempts to reason with patients about the importance of following medical recommendations (Weil 2009).

Working with Others

Each of the approaches discussed above, as well as the critical process of integrating them, can benefit from the observations and analysis of others.

Discussing a difficult case with a trusted colleague can go beyond processing one's emotions to include an exploration of what elicited the emotions and behaviors and how they resonate with the genetic counselor's life experiences (Bernhardt et al. 2010; Reeder et al. 2017). Peer supervision and clinical supervision in the workplace provide a regular, formal opportunity for discussing countertransference within the broader context of addressing clinical issues (Lewis et al. 2017; Zahm et al. 2008). The level of mutual support among clinical staff is also important in guiding a clinician's ability to address patient's responses (Evans 2006; Rolland 1994). Kennedy (2000a, 2000b) describes a leader-led supervision group that has functioned very successfully for a number of years. The papers that accompany hers in a special issue of the *Journal of Genetic Counseling* [*9* (5): 375–434] discuss specific cases, including ones in which addressing countertransference has been of great value to the presenting genetic counselor as well as other group members (Lewis 2002; Middleton et al. 2007).

Individual or group counseling or psychotherapy provides an opportunity to work in an ongoing, focused way with a trained professional concerning personal and interpersonal issues. Psychotherapy is usually undertaken from a desire to enhance the quality of one's own life and interactions. When personal issues, including countertransference, impinge on the quality of the genetic counselor's professional work, however, psychotherapy provides a means for addressing them directly. In this regard, Kessler has stated, "The responsible counselor has an obligation to be aware of countertransferential potentiality and, if necessary, to seek out and obtain professional assistance in dealing with clients who evoke such responses" (p. 308).

Summary

- Countertransference refers to the conscious and unconscious emotions, fantasies, behaviors, perceptions, and psychological defenses the genetic counselor experiences as a response to any aspect of the genetic counseling situation. It can include a broad range of conscious and unconscious emotions and psychological processes the practitioner brings to his or her work and that are elicited by the patient.
- There are two main types of countertransference: Projective identification and associative countertransference. Projective identification occurs when the genetic counselor over-identifies with the patient and mistakes their feelings for those of the patients. Associative countertransference results when the genetic counselor is unable to focus on the patient because they become immersed in their own inner experience.
- Six broad categories of life experiences can contribute to the universal experience of countertransference in genetic counseling: family dynamics, developmental life processes, life vulnerabilities, cultural background, professional training and socialization, and contemporary issues.
- Countertransference is inevitable in genetic counseling, and the impact can be adaptive, maladaptive, or both. Recognition and self-awareness often distinguish between whether countertransference is managed effectively or not.
- Genetic counselors can benefit from examination of countertransference experiences through individual self-reflection. Helpful questions for reflection include: What is (was my reaction (feelings, thoughts actions)? Why am I reacting (did I react) that way? Where did my reaction come from?
- Working with others through peer consultation and supervision can allow genetic counselors to explore challenging countertransference experiences in a more formalized manner to look beyond initial emotions at what elements of their patient interaction elicited the countertransference reaction.

Learning Activities

Activity 8.1 Dyadic Discussion

Working with a partner, take turns identifying three or four genetic counseling issues, situations or types of patients that are most likely to make each of you feel anxious, detached, annoyed, etc., or to engage in some sort of behavior that is not characteristic of your work with patients. These reactions may be indications that countertransference is involved. How well have you examined each of these issues/situations? Who might help you examine them? For each of the situations, identify one or more experiences from your life or habitual ways of responding to situations that may contribute to how you feel or act when providing genetic counseling under those circumstances.

Estimated time: 30–45 minutes.

Instructor Note

- Students could be asked to respond to these questions in writing prior to engaging in discussion.
- In lieu of a discussion, students could respond in writing only.