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Clinicians' experiences with child clients' explicitly stated love in the transference

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ABSTRACT

This study explored the experiences of clinicians in responding to their child clients' statements

of "I love you." It is clear that this experience is common amongst child therapists, but the

literature on this topic is virtually non-existent. While the literature does touch on

countertransference, therapy with children, and love in therapy, never has the literature touched

on the space in which these three topics come together. In order to explore this void in the

literature, this study was completed using a mixed-method, anonymous online survey. Thirty

clinicians participated in this survey, which asked clinicians to reflect on the interaction in which

their child client stated "I love you," By asking these questions, the study produced a collection

of data that will help future clinicians to consider the different ways clinicians respond to their

clients' statement of "I love you," what factors motivate a clinician's response, and what effects

these clinicians responses have on the child client, the therapy and the relationship. The findings

of this chapter indicate that while clinicians respond to such a statement in a variety of ways, it is

most common for clinicians to respond to their child client in a way that is largely dismissive or

avoidant of the statement. It is also common for clinicians to deny that their chosen response has

any effect on the therapy or the relationship. This thesis will provide an in-depth description of

this finding, amongst others, along with a discussion about the findings and their possible

motivating factors.

CLINICIANS' EXPERIENCES WITH CHILD CLIENTS' EXPLICITLY STATED

LOVE IN THE TRANSFERENCE

A project based upon independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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"It is not even possible for me to even enter my office in the morning of the clinical day without the hope and possibility of love." – Judith Vida

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CHAPTER I:

Introduction

In my second summer of the Masters of Social Work program at Smith College, I realized that my engagement with such an intense topic of authentic love and love in the transference/countertransference between therapist and their childhood clients was growing to the point of obsession. I thought about it constantly, toying with what I imagined different theorists might have to say about the topic and asking other MSW students and therapists about their experience. I would venture to say that almost all MSW students I asked about this agreed on one thing: They would not, ever, respond to any clients' feelings of love by asserting that they loved them back -- even if in their heart of hearts they truly did. When I asked why, most students could not give me a real answer. It just doesn't feel "ethical," they would typically point out. Students were also eager to distance themselves from loving their clients – describing that "therapeutic love" is, at its core, "different" in some ways from loving a friend, a sister, a parent, a child, etc., but they could not describe why It wasn't until near the end of my summer that I encountered any therapists who told me they told their own clients they loved them. It served a purpose. It was possible. People *did* do it.

I am haunted by a memory involving one of my seven-year-old clients during my first year placement in an elementary school. This child and I bonded greatly during my first few months at placement and I care about him and sometimes idealized him more than I suspected I would. I loved this client but was so uncomfortable with my love for

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him that when he first told me he loved me about five months into our time together, my response was "I think you are so special, and I really care about you." He did not respond. I think my words came up short, and I am left to wonder what might have happened if I was able to disclose my love for him more authentically – how would it have felt for him to know that someone he loved also loved him back, and that the relationship felt positive and consistent? Honestly, if I could do it again, I would tell him, "I love you back." Similar to my fellow students, I could not describe why I chose not to tell this client that I love him, other than that it felt I was doing something "wrong" or "unethical." I eventually finished writing a major case study on this client where I danced around the mutual love. I described myself as a "vehicle" for this client to experience care and a "holding environment." Clearly, it was very easy for me to find theories that could back up my decision not to disclose, and in writing analytically and clearly I could deny my feelings with hundreds of years worth of psychoanalytic pioneers to stand behind me.

I admit that this study is somewhat motivated by this experience and a chance to vicariously live and reflect through therapists that have reacted to this experience in the same way I did, or differently than myself. I wholly encourage others who might read this thesis to question how my own experiences may have tainted by results or interpretations, or perhaps the ways in which I have chosen to analyze relevant literature. Alongside my own longing for answers to the question of how therapists deal with a child client's admission of love towards the therapist, this study also aims to fill a gap in literature. In my searches of the available research (which are outlined in Chapter II) I did not come across any literature that directly attempted to explore ways in which therapists might

respond to a child client's telling them "I love you." I find this curious, and I wonder if individuals feeling so uncomfortable with the possibility of such an interaction directly cause the omission of such a topic from the literature. But, in a field that attempts to make the unknowable known, and to make the taboo a topic of conversation, how has this common phenomenon never been addressed or explored?

Therefore, the purpose of this study is to explore the ways in which clinicians respond to their child clients when the child client tells the therapist "I love you." This study also aims to consider the motivations behind a therapist's response, along with the effects of the response on the client, the clinician, the therapy, and the therapeutic relationship. These research questions will be explored deeply through a review of relevant literature (Chapter II), a mixed-methods study methodology (outlined in Chapter III), a presentation of the findings (Chapter IV), and a discussion of the results and their congruency with my expectations and the published literature, as well as suggestions for future research (Chapter V).

CHAPTER II:

Literature Review

This chapter will review the literature on three separate, yet intertwined, topics related to love in the (counter)transference between clinicians and child clients. The subsets of literature will include: a historical perspective of classical understandings of countertransference and transference, a modern perspective on love in countertransference and transference, and countertransference and transference with child clients.

Introduction

Accessibility to literature on the topic of explicitly stated transferential love and its interactive meeting with the countertransference between clinicians and child clients is extremely limited, and it clearly dwindles as it becomes more and more specific. However, while broader topics of (counter)transference, love in the (counter)transference and (counter)transference with child clients seem to barely scratch the surface of this specific topic of explicitly stated love in the transference with child clients, literature related to such topics, though broad, is invaluable to the understanding of this research as being controversial, complex, and one of much fluctuation over history. Literature contributing to an understanding of such relevant topics first requires a broad understanding of developments and undulations of focuses on (counter)transference in traditional psychodynamic theories. This preliminary section will most specifically focus

on the related thoughts of the father of psychodynamic theory, Sigmund Freud, the eventually nearly censored thoughts of Sandor Ferenzci, and the movement to address countertransferential hate by D.W. Winnicott. The second section of the literature review will highlight more modern understandings of (counter)transference and love that are most notably addressed by Irvin Yalom, Karen Maroda and writers of intersubjective and relational theories. Finally, this research will require an understanding of literature specific to (counter)transference with children – largely in regard to the highly researched phenomenon of the "rescue fantasy" and Annie Roger's acclaimed memoir of a tragic dance with a therapist's vulnerabilities and the (counter)transference arising with a traumatized child client. This literature review will end with an attempt to weave traditional and modern theories of countertransference and transference with the rare explanations of how they might apply to children. What can be discovered is that the literature is often conflicting, leading one therapist to question the variety of possibilities and implications of how to deal with a child client's explicitly stated love in the transference. This is what this study will aim to consider.

A Classical Understanding of (Counter)transference

Although Freud was the first analyst to introduce and discuss the concept of countertransference and assign its terminology in 1910, much of Freud's work on the therapeutic relationship aimed at highlighting transference as useful and analyzable, while simultaneously attempting to relieve himself and his followers of the "burden" of countertransference (Bodenheimer, 2010). In Freud's mind and teachings, the therapist's feelings towards the client are of a dangerous nature to even possess, and even more dangerous to address or entertain. It is said that perhaps Freud's aim to avoid and ignore

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countertransference stems from a difficult relationship with a young patient in 1905 –

"Dora." Freud's piece "Fragment of an Analysis of a Case of Hysteria" outlines his

relationship with 16-year-old Ida Bauer ("Dora"). While the two became very close over

a three month period, Springer and Bodenheimer (2010) argue that this specific case

illustrates a development of Freud's countertransference towards "Dora,"which

eventually resulted in a therapeutic relationship that was "short of good analytical

practice" (Springer, 1995). Springer and Bodenheimer agree that Freud's

countertransference towards "Dora" resulted in processes in which it seemed Freud was

striving to be recognized as not only as an analyst or therapist, but also male, a human

being, and perhaps someone with similar feelings or thoughts as "Dora." In this way,

Freud's perhaps unconscious feelings towards "Dora" (whether they were parental or

romantic is largely unimportant in this case), were brought to life and action in session –

eventually negatively affecting the work. Shortly following Freud's "coming apart"

(Springer, 1995) with "Dora," he continued to denounce the importance and utilization of

countertransference in discussions with Carl Jung. In a letter to Jung, Freud describes

countertransference as feelings that must be "dominated" by developing a "thick skin"

(Bodenheimer, 2010). It seems, then, as if Freud's conceptualization of

countertransference is one that is (a nod to the construction of the term) the exact

opposite of transference in more ways than one. Most concretely, countertransference is

the reverse of transferential feelings in the therapeutic dyad. However, perhaps more

important for Freud, the prefix of "counter" is most closely referencing the ways in which

transference is useful, helpful and analyzable, while countertransference is just the

opposite – dangerous, useless, inappropriate, and derogatory. Throughout the rest of

Freud's career, he maintained such negative opinions of countertransference, eventually embodying the proverbial "blank slate" many imagine today when considering psychodynamic theories and psychoanalysis.

What is unfortunate about the commonly evoked concept of the proverbial blank slate, void of countertransference, is that it is has successfully censored the early thoughts and writings of Sandor Ferenzci, a once close friend and student of Freud's. Freud and Ferenczi first began interacting in 1907, writing more than 526 letters to one another in the matter of Seven years. Ferenczi was analyzed by Freud, was one of students and friends, and eventually became a theorist to challenge Freud's staunch stance on countertransference. A proponent of the radical concept of mutually analytic relationships, Ferenzci proposed that the core of the therapeutic relationship was "absolute mutual openness" that accompanies the "curative tenant" of brave authenticity (Bodenheimer, 2010). In other words, Ferenzci did not only acknowledge the possibility of the therapists having feelings about the clients (which Freud was even resistant to admit), but he bravely encouraged the therapists to be open with the clients about their feelings. What is even more is that Ferenczi believed even if the patient was not explicitly made aware of the therapist's conscious or unconscious feelings in the relationship, they would eventually become evident. In Ferenczi's paper *The Confusion of Tongues* (which Freud regarded as "dumb"), Ferenczi states, "I came to the conclusion that the patients have an exceedingly refined sensitivity for the wishes, tendencies, whims, sympathies, and antipathies of their analyst, even if the analyst is completely unaware of this sensitivity" (Ferenzci, 1933). In other words, not only does Ferenzci argue against Freud, asserting that countertransference is perhaps equally as important and useful as

transference, but he also argues that anyone would be a fool to think patients did not "pick up on" the therapist's countertransference regardless of disclosure. In this way, what is the point of non-disclosure – as it could certainly amount to increased neurosis on the part of the client when met with the "blank slate"? While Freud considered transference one of the important keys to understanding the client's unconscious, Ferenczi ventured to note that perhaps transference and countertransference were equal in importance to this process. Although Ferenzci was well written on this particular topic, Freud's opinions, writing and research somehow managed to completely outshine the likes of Ferenczi. Speaking to this, Martin Cabre (1998) writes, "as a result of one of the most remarkable processes of censorship in the history of psychoanalysis, Ferenzci's ideas were "forgotten" and condemned to silence" (Martin Cabre, p. 247). Although Martin Cabre postulates a variety of political phenomena that may have caused this censorship, one cannot help but wonder if the very uncomfortable nature of the topic led to its disappearance.

Almost 40 years after the feud between Ferenczi and Freud became a shadow and Ferenczi's theories and research on the importance of countertransference fell even further behind the advancement of Freud's "blank slate" approach, D.W. Winnicott emerged with a new and surprisingly far less controversial understanding of the therapist's feelings towards the client. Winnicott's 1949 paper *Hate in the Countertransference* served to legitimize Ferenczi's assertions that perhaps countertransference is equally as useful, informative and unavoidable as transference – but in a way that is very different than Ferenczi seemed to intend. While Ferenzci's papers typically focused on the therapist's love for the patient and the central importance

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of guiding love and mutual understanding in the therapeutic relationship, Winnicott

argued that countertransferential hate was common and largely unavoidable – mostly in

the way that Winnicott believes mother's typically hate their children before the baby can

even hate them (Winnicott, 1949). The process of nearly complete removal of Ferenzci's

thoughts on countertransference, only to be replaced with those endorsed by Winnicott, is

completely fascinating and brings up many questions to consider regarding what is

comfortable (and what is not) for a therapist to experience with a client – and why is this?

Why were feelings of love and attunement shunned in the therapeutic community, and

why were feelings of hate and disdain highlighted and explored?

Many theorists would venture that perhaps it feels "easier" or more acceptable to

rid the self of positive, loving countertransference than it is to "deal with it" for a variety

of reasons. In this way, the undulations of the classical psychodynamic understandings of

countertransference have lasting effects in modern communities. Primarily, as

Bodenheimer asserts, Freud's attempts to "dominate" countertransference through the

development of a "thick skin" are often mirrored in today's communities of budding

therapists and master's of social work students. She writes, "I cannot count the number of

student papers I have read that mention "countertransferential feelings" and the students'

"plans" to rid themselves of them" (Bodenheimer, 2010). Furthermore, Baur (1997)

comments on the lasting effects of Winnicott's discussions of hate, and how they

eventually came at the forefront of countertransference discussions, even over Ferenczi's

discussions of love and countertransference 40 years prior. Investigating this, Baur

asserts that when attending a seminar on countertransference, she noted that the word

"hate" was said 40 times more than the word "love." Furthermore, she adds that a

clinician's assertions of feelings related to hate were often met with questions and interest, while assertions of feelings related to love were met with silence – a shocking process enacting the differences between Ferenczi's and Winnicott's differing impacts on the same broad topic (Baur, 1997).

But now we must ask, why does this occur? In the same paper, *The Intimate Hour*, Baur asserts that perhaps some of the therapists' comfort with hate over love lies in our worries of creeping into risky territory – a place where our love for our clients might too closely mirror romantic love or erotic fantasy (Baur, 1997). By not wanting our love for our clients to cause others suspicion of our motives or interests, we gladly withdraw our love in service of reducing our own discomfort, a process that Ferenczi would argue as useless, as the patient can typically see through our walls as quickly as we can put them up.

Modern Reemergence of Love in the (Counter)transference

Despite the long traditions of avoiding the concept of therapeutic love, a resurgence of Ferenczi's theories and research in the field of relational therapy and intersubjective theories has, once again, introduced therapeutic love to the community of long deprived therapists and those patients which they treat.

Karen Maroda, author of *The Power of Countertransference* (2004), speaks directly and deeply to developing responses to countertransferential and transferential love. Calling upon the influences of authenticity and mutual openness endorsed by Ferenczi and opposed by Freud, Maroda provides readers with an example of transferential disclosure, and the way in which it mixed with her own fears, anxieties and countertransference. Early in her career as a psychotherapist, Maroda began to treat a

young woman who was experiencing feelings of self-dislike and anxiety related to a well-known feeling of being "unloveable." When Maroda's client asked Maroda to disclose her feelings towards her – Maroda's response ("I like you") fell short, and eventually caused narcissistic injury that would eventually manifest as physical illness. Upon discussing the transference and the need for disclosure on the part of her client, Maroda eventually disclosed that she did, in fact, love her patient. Maroda's patient was angry, and quickly questioned why Maroda would not have disclosed such a feeling in the first place – especially when it was so clearly in service of the patient's goals for treatment (how might she feel loved?) and a response to her transference neurosis. Describing the motivations behind her decisions to withhold, Maroda writes, "I found that my training actually hindered me in my efforts to address her needs in the therapy relationship…had I been able to confront my countertransference with her more directly… the outcome of her therapy may have been different" (Maroda, p. 140). In Maroda's own personal processes and her struggle with her patient, she changes from classical education (i.e., Freud, Winnicott) to one that is more Ferenczi-influenced (Intersubjective theories). Maroda's course of treatment serves as a beautiful metaphor for the changes in literature and theory – feelings of hiding, of feeling limited, and of being withholding eventually are met with frustration and anger, taking time to turn into a process of mutual openness and trust.

Maroda also challenges the use of the word "love" in therapy directly. She offers that while it is certainly worth considering some completely possible negative outcomes (imagined or real eroticism, a seeming or real "over investment" in the patient) of using "I love you" in therapy, obvious substitutes (i.e., "I care about you") fall short and may

tend towards causing narcissistic injury (Maroda, 2004). Coupled with Ferenczi's

assertions that our clients are much more astute than perhaps we would like to imagine, a

substitute or a "white lie" for the purpose of upholding professionalism (even with the

love is or isn't true and real) is somewhat purposeless. Speaking to this, Maroda writes,

> For some time I tried to circumvent this problem by not using the word
> "love". Instead I used replacements like "care deeply" or "very fond of."
> This worked, and was even preferred, by some patients. But others
> considered it as a "cop out" and were annoyed or hurt by my reluctance to
> use the word "love". Was I ashamed of it? Why couldn't I use it? Didn't I
> really feel that strongly? So I abandoned my attempt at simplicity and now
> use the word when applicable, always prepared to explain what I mean by
> it so that the patient does not confuse my expression of deep affection with
> the declaration of romantic love. (Maroda, p. 141)

A larger and less theoretical response to (counter)transferential love in the clinical

hour belongs to Irvin Yalom. Yalom takes the time to transform the clinical "dilemma" of

love and the use of love into one that is clearly less theoretical and more humanitarian.

For Yalom, when the basis of therapy is the process of loving, how can we tremble at the

thought of love in the (counter)transference when it is possibly innate. In other words, for

Yalom it seems almost obvious that love will exist in the therapeutic relationship. This

idea of almost instinctive and underlying, humanitarian love is echoed in the thoughts of

Judith Vida, contemporary relational psychoanalyst. When Vida is asked to consider if

she imagined that the existence of love could ever be useful in the therapeutic dyad, she

responds,

> It is not even possible for me to even enter my office in the morning of the
> clinical day without the hope and possibility of love… How can I say what
> it contributes when it is not an option or a conscious choice whether it is
> there or not? This is like saying, "Does it contribute to the therapeutic
> action that the analyst draws a breath, has a blood pressure and a pulse?"
> (Vida, p. 437)

So beautifully spoken, Vida comments on an important advancement that relational therapy and existentialist Yalom both bring to the concept of love in the relationship – that it is expected, obvious, and intrinsic. While Freud clearly imagined countertransference was a decision to either engage with or not, Yalom and Vida, along with many other contemporaries including Shaw (2003) and Natterson (2003), argue that it is not an option, and that it is even desirable.

In his book *The Gift of Therapy*, Yalom offers that while the therapist should be sure to monitor the feelings and shifts of the loving relationship, the therapist must also accept as is. He writes, "the therapeutic bond can become so strong – so much is revealed, so much asked, so much given, so much understood– that love arises, not only from the patient but also from the therapist, who must keep in the realm of caritas and prevent its slippage into eros" (Yalom, 2002). Here, Yalom successfully manifests another modern trend in the understanding of love in the (counter)transference as Yalom calls attention to major point of difficulty that arises when clinicians speak about love in the therapeutic relationship: the confusion between different "types" of love.

In the English language, we are required to use one word, "love,"
to signify feelings of tenderness, care and interest in a variety of ways to a variety of subjects. While we might "love" the color red, we also "love" our parents, our children, our romantic partners, teachers, mentors, certain foods, etc. Certainly, this is not necessarily a problem in most other languages that often use different words for the different ways in which love is manifest (i.e., the Latin caritas vs. eros). As our brains aim to categorize to the best of our abilities, theorists have been attempting to write about a phenomenon of specific love (therapeutic love) that does not necessarily belong in the

same "box" as one's love for a friend, child or a romantic partner. While such other sentiments are certainly obviously intense, the feelings of therapeutic love become quickly lost in other meanings. As Natterson (2003) offers, therapeutic love is a "specialized mutually loving relationship" (p. 510). Here, Natterson is perhaps hinting that the therapeutic relationship is serving the purpose to "just love," something that is not necessarily true for most other relationships that value love and care. Still however, our language to describe such a phenomena is limited, leaving us with terminology that is loaded with assumptions often closely linked to our own pasts and the pasts of our clients. In this way, if our clients tell us they love us, or if we tell our clients we love them, what "type" of love is this we are speaking of? Or, perhaps more important, what "type" of love could this be misinterpreted as because of our inabilities to name our experience without linking it to something different from what we might mean? For example, if the therapist is disclosing feelings of therapeutic love ("specialized mutually loving") and the client interprets the word "love" to be laden with eroticism and power, how might this be navigated or explained without the words to do so?

As the writer, I am also aware, at this point, that I am making the conscious decision to ignore influences of literature specifically highlighting erotic (counter)transference, and that much of the literature highlighted above and below assumes a grain of "innocence" about therapists and clients that discounts the possibility of romantic love or eroticism. Of course, this phenomenon of erotic (counter)transference does commonly exist and is occasionally expressed and unethically acted upon. It is true that sometimes statements of "I love you" in the dyad are actually meant to embody romance and eroticism. Interestingly enough, literature on this "type" of love in the dyad

seems to be studied at a degree much larger than the "specialized" love of therapy.

Perhaps in a way to lead into something more obviously uncomfortable (client-therapist eroticism) to avoid the inexplicable discomfort of authentic love, many authors have grappled with how to approach or not approach such sexual feelings in the therapeutic relationship. These articles, especially Schamess (1999) and Rabin (2003), deal with approaching eroticism in a very practical way. In other words, these authors actually give advice on how one might deal with and express such feelings. Of course, actual advice or concrete ideas are not present when considering this other, specialized, authentic love. For the purpose of this paper, I will not consider perspectives on dealing with such an issue as erotic (counter)transference, as it much less applies to children.

(Counter)transference with Children

Considering the phenomenon of (counter)transference with children, especially in terms of love and closeness adds a layer of difficulty that is unique with an extra layer of ethical issues. Clinicians practicing therapy with children might encounter 3 specific dilemmas related to (counter)transference – the seeing of the self in the other, the rescue fantasy, and the complexity of "love" for a child.

It is important to recall that the very term "transference" was classically thought to embody what the patient thinks about therapist – but most specifically, why the patient has such fantasies or feelings about the therapist. Classical ideas of transference suspected that transference occurred when the therapist reminded the patient of someone else from the patient's past. In this case – the patient would assign a variety of feelings, tendencies, fantasies and motivations to the therapist, which is analyzable in the relationship. In countertransference, the therapists assign their own experiences to the

patient, which, if dealt with correctly, can be understood and useful instead of having many negative consequences. Certainly, when the therapist is engaging with a child client, the (counter)transference is complicated. Annie Rogers' book *A Shining Affliction* (1996) is a beautiful memoir outlining some of the complications of (counter)transference in child-clinician relationships. Rogers is a therapist who has endured a great deal of childhood trauma, which was largely kept "at bay" and below the surface for much of her life. Early on in her learning at an internship for children with trauma histories, Rogers engages in play therapy with a young client, Ben. Ben's own experiences of trauma and abandonment become evident in their sessions together as the two often act out imagined situations of abandonment and reunion, eventually forming a strong attachment. It is during this time that Rogers experiences an influx of early memories related to her own childhood traumas, which eventually push her into a period of psychosis and hospitalization.

Rogers loved and cared for Ben in a way that was deeply evident. Rogers is not shy in describing how she thought of Ben often, sometimes waking up to dreams of him and missing him deeply during her hospitalization. Through this loving relationship, however, Rogers' countertransference towards Ben took the shape of seeing herself, her early pain and trauma within Ben's story. This was deeply painful for Rogers and eventually was one of the larger causes of her psychosis. It seems common that many therapists might experience countertransference of child clients as a way to relate to their own young selves, or the young selves of close friends or family. Certainly, this experience can be excruciating for therapists working with young clients.

It is also clear that Rogers' patient, Ben, deeply loved and cared for her. Rogers describes how Ben repeated, "I love her" over and over when writing a card for her in the classroom before their termination. Of course, early on in their relationship, Ben seemed to expect Rogers would abandon him – a pattern assumed by his transference towards Rogers. As Ben's experiences of older women is greatly influenced by his mother, a major part of his abandonment, it is no wonder he would expect others to do the same. When Rogers eventually returned from her hospitalization, Ben continued to express his experiences of transferring memories and feelings about his mother onto Rogers, as he wondered out loud if he had made Rogers "go away" and "get sick." It seems, then, as if a major barrier involved in transference of child clients is the transference of feelings about caregivers being brought upon the therapist. With so many child clients having adverse experiences with caregivers, this is no easy feat to endure. Especially when child clients remind therapists of their own traumatic childhoods or the childhoods of others that were left "unsaved," many child therapists fall into feeling the need to "rescue" patients from their past experiences as they take on the new roles of imagined primary caregivers – just as Rogers eventually had to do with Ben.

Although the majority of this paper has focused on areas that are lacking in terms of literature, the concept of the "rescue fantasy" is a phenomenon that is actually clearly researched and theorized. Theorists such as Esman (1987) and Malawista (2004) write that although the concept of rescue fantasy is clearly very applicable to child therapy, the concept has been classically applied to most therapeutic relationships. Malawista notes that Ferenzci (1919;2007) described that "the doctor has unconsciously made himself his patient's patron or knight," and that Freud (1910) often wrote about the "rescue of the

fallen woman." It is clear that the classical opinion was not to deny the possibility of the therapist "saving" the patient, but also to assume that it was unconscious occurrence or an occupational hazard – something the therapist did not necessarily "want" to happen, but something that just simply occurs over the course of treatment.

New theorists of rescue fantasies, especially with children, such as Esman and Malawista describe that many therapists actually choose to engage the recue fantasy, even if it be an unconscious decision. Perhaps most controversially, Bernstein and Glenn (1978) write that the "wish to be a child analyst frequently stems from the analyst's maternal identification and an unconscious wish to have a child" (Benstein & Glenn, p. 380). These theorists point out that it is typical for both patient and therapist to actively engage rescue fantasies in the child-therapist relationship. The therapist actively assumes the role of the "good object," the "rescuer" and the "good, new parent" to love the child in a way that is reparative, and the child client often actively seeks the comfort of the therapist in a way that is either maternal or paternal. This, of course, often affects the relationships between the therapist and the caregivers, often creating feelings of jealousy, hate or concern. In the case of Rogers and Ben, the countertransference involved the wish to rescue Ben (clearly, not only Ben but also, subconsciously, Rogers herself, through Ben). Similarly, Ben engaged in the rescue fantasy by seeking Rogers as a substitute for his own traumatic relationship with his parents through Rogers.

Considerations of the rescue fantasy and the real risks of transference in the child-therapist relationship only further complicate the use of the word "love" in with child clients. While it is clear that both Rogers and Ben love one another, the rescue fantasy concept begs the question – what kind of love is this then? Certainly, this sort of love

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might not be the sort described by Natterson ("specialized mutually loving"), as its actual aim is to resemble the parent-child relationship as closely as it possibly can. Also, if the aim is to mimic the fantasy of a child and his/her parent, what are the implications of using the word "love" in the therapeutic dyad? If our child patients love us, does that mean they love us as they do their own parents? If we love our child clients, does this mean that we love them as we might love our very own children?

When Maroda speaks of loving her own clients, she describes how she is always prepared to explain what she "means" by loving them – perhaps in order to ensure the patient does not think the therapist is "in love" or sexually interested in the client. Love with child clients also necessitates, perhaps, considering the child's experiences with love in the past. If love has been painful, or non-existent for the child client, the therapist must be prepared to either explain the intent or to use a substitution. If the child client has a very loving relationship with his or her parents, the therapist must be prepared to explain how the love might differ, and how to cope with feelings of guilt from the patient for loving another adult. If a child has not yet felt the positive experience of love, the use of the word could be necessary and curative. Clearly, in short, love in therapy with children might be expressed differently with adults than it might with children, with entirely different conversations and consequences.

Conclusion

Considering the literature on the topics above provides an extensive, yet not exhaustive, background to consider when beginning to understand the very specific phenomenon of how to address explicitly stated transferential love in the therapeutic dyad with child clients. Literature on the topic of classical understandings of

(counter)transference illustrates early fears, neuroses and eventual avoidance of countertransference, coupled with the censorship of Ferenczi's ideas of mutual, complete openness and later reemergence of countertransference with hate and Winnicott. Literature related to ta more modern examination of love in the (counter)transference illustrates an effort to normalize feelings of love and care on both a clinical and theoretical level, while also describing the challenges of such a topic (namingly, use of language and ensuring understanding). Lastly, literature on (counter)transference with children focuses on common fantasies of rescue and their consequences. Still, despite such an attempt to sift through over a hundred years of theory and research, the research question has yet to be addressed or answered. All of the literature drawn upon still does not provide an adequate answer to how clinicians might deal with confessions of "I love you" from a child client, and what the consequences to using different answers might be. And with this background, this study will hope to answer this question.

CHAPTER III:

Methodology

Introduction

This chapter will review the methodology for the study that has been completed

on the topic outlined and researched in the previous chapter. This research project aimed

to answer the questions: What are the theoretical, practical and emotional aspects of

clinicians' responses to such explicitly stated transferential feelings of love from a child

client? What are the implications of these responses for the client, the interventions, the

alliance, and the therapists' own hearts and minds? In short – How do therapists respond

when their child client says "I love you," why do they choose the responses that they do,

and how do these different responses affect therapy? I chose to answer this question using

a mixed-methods online survey that is primarily phenomenological in nature. This study

is considered phenomenological as it aims to understand the "essence" of such a shared

experience – in this case, the experience in which a child client tells their therapist that

they love them.

I chose this method primarily for four reasons: 1) The online survey setup allowed

for complete anonymity for a topic that I found to be ethically challenging, 2) The

accessibility of an online survey for a wider audience, 3) An online survey provides

subjects the time to reflect upon their answers without awkward silences or pressure to

speak (I expected this would be useful since many of the questions ask the subject to

recall an event that could be far in the past), and 4) a mixed-method survey allows the researcher to ask questions that are both open ended and broad, as well as questions that are more specific and poignant. Open-ended, broad questions provided the subjects with the space to divulge as little or as much as they would like about their experience with their clients without a great degree of direction from the researcher. Poignant multiple-choice questions allowed me to gather and higher degree of data regarding the subject and the sample while maintaining anonymity. Furthermore, I found that this method of study is congruent with the very limited amount of data and research already available for this specific topic. In its very nature, this study is exploratory: exploring the reasons behind the actions of clinicians and the effects of their actions in therapy. Because I could not find any previously gathered data with clinicians' examples of how one might approach such a situation with a child client, this is where I was forced to begin to explore the topic.

Sample

The method for creating a sample for this study was snowballing. In order to identify the participant pool, I asked friends, classmates and family to forward the survey to anyone they believed might fit the criteria for a participant (see more below). These could be MSW students who have had supervisors that fit the criteria, friends who know therapists who fit the criteria, etc. When the survey had been created through Survey Monkey, the link was clear and easy to forward to others. If participants required a more formal email, a version of the recruitment letter (Appendix C) was forwarded. The method of snowballing was used primarily for accessibility and ease. I aimed to gather as

many research participants and completed surveys as possible. While I now realize this is somewhat lofty, I originally was aiming for about 50 participants.

Following these steps, the potential participants completed a screening process. Once they had visited the survey link, the first page (prior to informed consent) highlighted the inclusion criteria, asking participants to either continue with the survey if they met criteria, or to exit the survey if they did not. The inclusion criteria were as follows: The survey was available for clinicians who hold a master's degree (or above) in social work, psychology, or a related therapeutic discipline; who have a license to practice such as the LCSW or LICSW, or equivalent license in a related discipline; who practice or have practiced individual therapy with children under 12 years old; and who have had the experience of a child client stating "I love you" in session. The inclusionary criteria existed to ensure that the participant had a higher level of education to suggest an understanding of theory, practice and ethics, and had a clinical license to suggest experience in the field and clinical education. These criteria also ensured that the participants had worked with children in an individual setting to suggest a therapeutic alliance and constancy, and to ensure that the participants had the experience in question (responding to a child client's stating "I love you"). Participants could not be deemed "ineligible" on the basis of age, years of experience post-licensure, theoretical orientation, gender, religion, race, sexual orientation, ability, etc.

A snowballing sampling method for an online survey certainly has the benefits of ease and accessibility, but also presents a few issues in regards to diversity and feasibility. In terms of feasibility, it is certainly somewhat difficult to ensure that those who are reached by recruitment emails or posts will complete the survey. While many

potential participants are reached, it seems that surveys might slowly move to the bottom

of one's inbox over time, given that there is not a specific time set to gather data and

complete the answers. Of course, while qualitative interviews lack accessibility,

anonymity, and the ease of an online survey, the do create a specific block of time in

which the questions will be discussed and completed. In an anonymous, mixed-methods

online survey, it is up to the participant to find the time to do so – which can pose

challenges for reaching a high sample number. Snowballing also presents specific

disadvantages for diversifying the sample. Of course, when a participant emails the

recruitment letter to possible participants, it is highly likely that this group of participants

will be similar – perhaps they know of each other through working at the same agency,

through similar geographic regions, through social circles, etc. Furthermore, because the

survey was anonymous and I could not quite control who took the survey, I was mostly

unable to control the level of diversity for many factors: race, age, socioeconomic status,

geographic region, sexual preference, gender, etc. In this way, I understood that my

sample would likely be somewhat small and lacking in diversity because of the sampling

method.

Ethics and Safegaurds

This survey was completely anonymous. I did not have any interaction with

participants unless they chose to contact me regarding the survey or research via email or

phone. This happened once, as one participant reached out to ask a question about their

eligibility for the survey (but it remains mostly impossible for me to match answers to the

possible participant). Because the survey was online (there was no option for paper

copy), it was automatically ensured that the participants could not be linked to their

answers because they were not asked of their name or contact information. The survey did ask for some potentially identifiable information (years in the field, race, gender), but was vague enough to not make identifying participants possible.

Anonymous participant responses were recorded in an online survey. From this survey, the responses were seen by the researcher and were eventually printed. Even though the responses maintained anonymity, the responses were kept in a secure file close to the researcher without full access to others before the production of this thesis. All research responses and analyses are being kept in a secure location for three years according to federal regulations for research involving human participants. In the event that these materials are needed beyond this period, they will be kept secured until they are no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

The following paragraph describes participant risks that were associated with the participation in this study: While I did not expect that this survey would make for participants to feel more than mildly uncomfortable, it is possible that the survey could have evoked feelings of guilt, shame and regret about the actions of the therapist, however unintentional. In order the avoid and mitigate excessive discomfort, the survey questions maintained neutrality – therefore not suggesting that the therapist "should have" responded in a specific way, and not suggesting that one response is somehow "better" or "more effective" than another. If the survey did evoke feelings that were beyond mild discomfort, the participants always had the option to end the survey, and therefore withdraw from the study, without penalty, at any point. Because all participants

were experienced clinicians, counseling resources were not offered, as it was presumable that such persons would be aware of the resources open to them.

Potential benefits for participants included an understanding that they might have contributed to a larger understanding of the topic for the researcher, those who read the thesis, and those to whom which the knowledge is disseminated. Potential benefits also included allowing the participants a place to reflect on an important experience with a client, which could potentially influence their work in a positive manner.

Data Collection

Data used for this study were collected through Survey Monkey, a popular online source for data collection in the realm of mixed methods, quantitative and qualitative surveys. Survey Monkey maintains anonymity for participants if necessary and allows the researcher to construct a survey with questions that can be answered in a multitude of ways. My survey (the entire copy of which can be found in Appendix D) included three different types of questions and are described as follows:

Multiple Choice – Choose one answer. I typically used this type of question when attempting to gauge the answers to question that were on some sort of "scale," required an answer that is a number or within a range, or "yes or no." Some of these questions included: Do you have any children of your own? How many clients have told you they love you? And describe your level of anxiety (if any) about producing an answer for your client.

Multiple Choice – Choose as many as apply. I used this type of question mainly for questions in which the participant could have a few different answers. This type of question was particularly important to include when determining the demographics of the

participant, as many individuals choose to identify with more than one race or ethnicity, or more than one gender expression. Some examples of these questions included: Did you use any supports to discuss your countertransference? What races or ethnicities do you identify with?

Open ended questions. This was the most frequently used way in which I asked questions to participants. I used open ended questions, sometimes with a follow up question, to prompt the participant to comment. The participants could write as much or as little as they wished on the topic. Some examples of these questions included: Please describe any countertransference you were aware of towards this client. What was your client's response to your answer? Do you think your response influenced your relationship or the treatment in any way? If so, how?

Choosing what type of question to use was, at times, a complicated process. While I understood that most of my questions could not adequately be answered by multiple choice (even "choose as many as apply"), there were some questions whose format would clearly be challenging to choose. For example, the question that asks participants to rate their anxiety could, theoretically, be asked in many ways (open ended, on a number scale, with a sliding bar, etc). I felt that participants' answers to this question in an open ended, qualitative form would have been difficult because it would have involved a great deal of interpretation and understanding of subtleties to quantify one's anxiety. Furthermore, for the sake of the study, I felt this was a question I needed a definitive answer to. I needed to know how anxious clinicians felt and providing participants with a scale of options was the best way to determine this accurately. Overall, my survey included six multiple choice questions in which the participant could

choose only one answer, four multiple choice questions in which the participant was promoted to choose as many as applied, and nine open ended questions.

It seems as if the reliability and validity of largely open-ended, qualitative questions are fairly high, as long as the researcher is sure that the questions are asked in a way that is straightforward and clear. Of course, this was difficult to ensure at times. Particularly with questions that are complex, a researcher can only ensure high validity if they are sure the question is asking what it is supposed to ask, and if the researcher is sure that the questions being asked cover all the bases of the research topic in question. The researcher can only be sure of high reliability if they can ensure that the questions will produce the same answer each time with the same individuals.

The domains and variables being considered in this study are: the individuals reasoning for developing a response to the client's statement of "I love you, " the response the clinician exhibits, and the effects of the response on the relationship.

Data Analysis

The process of data analysis for the majority of this study (the qualitative portions) will be done through coding – primarily, reading and studying the responses of others to determine what themes emerge, and if there are any clear connections between some themes and other themes, or apparent contrasts between them. In order to ensure the validity of the themes, using a brief "second coder" is possible. In this way, the researcher can be sure that the themes are clearly illustrated in the responses and not entirely created out of the researcher's biases. The more quantitative portions of data analysis are more simple to describe and can be statistically quantified through Survey Monkey. The process of coding, coupled with quantitative data analysis, can help

develop connections between quantifiable themes (i.e., anxiety level) and qualitative

themes (i.e., response produced by a clinician). Other quantifiable data, such as

demographics, can be easily statistically quantified through Survey Monkey to determine

the diversity of the sample.

CHAPTER IV:

Findings

This chapter will analyze some specific findings of the research study proposed and approved by the Smith College School for Social Work Human Subjects Review Committee, and described in **CHAPTER III – Methodology**. This chapter will begin with a simple "breakdown" of the diversity of the participant sample recruited, and a discussion of other quantitative data (practice settings of participants, resources and supports used by clinicians for both processing countertransference and processing the "I love you"-situation, and the level of anxiety reported by clinicians). Next will follow an analysis of the qualitative data respondents offered, including the ways in which clinicians interpreted and understood their countertransference towards child clients, the ways in which clinicians respond to expressions of love, and the ways in which clinicians believe such expressions and the responses made to them affect the therapeutic relationship. This chapter will conclude with a description of some particularly interesting participant answers that highlight the complexity, and thoughtful nature of many responses.

Sample Characteristics

This study was created through Survey Monkey (www.surveymonkey.com), and was kept open for responses from 11/22/2014 until 3/22/2015 (a total of four months). The methods for recruiting these participants are outlined in **CHAPTER III –**

Methodology. Use of snowballing through social media and email to professional and social connections were the methods that proved to yield the highest number of responses. During the four months that the survey was available to participants, 30 individuals opened the survey link and consented to participate – which required agreeing that each met a set of inclusion criteria. Of these 30 eligible participants, four participants exited or "withdrew" from the survey immediately after consenting to participate. Of the 30 participants, six participants only partially completed the survey. Of these six participants, three withdrew at question four ("Without disclosing any potentially identifying information (name, location, etc), please describe the client you are thinking of in a few sentences"), two withdrew at question five ("Please describe any countertransference you were aware of towards this client"), and one withdrew at question 10 ("What was your response when the client stated, 'I love you'"? Please try to quote verbal responses if possible and describe nonverbal responses as clearly as you can remember them). Of these 30 participants, 20 participants completed the survey through to the end. Still, some of the remaining 20 participants chose not to answer some questions. Five participants skipped question five ("Please describe any countertransference you were aware of towards this client"). Two participants skipped question eight ("What races or ethnicities do you identify with? Please check all that apply"). Nine participants skipped question 29 ("Is there any other information you would like to offer about this topic?"), and 11 participants skipped question 35 (Do you have any suggestions for improving this research study?"). The many answers to this study vary in degree of thoughtfulness and length. While some answers are quite short

(perhaps one sentence), others were well thought out and offered in well formulated sentences, suggesting a high degree of reflection and care.

It is important to keep in mind the diversity of the sample when considering the following participatory answers. I would consider this sample diverse in a variety of ways and lacking diversity in other ways.

Themes of experience. Question 30 addressed the level of experience (in years) for the participants. Twenty participants answered this question. Forty percent (n=8) of participants described having practiced or having been practicing individual therapy with children for more than 10 years. Five percent (n=1) reported being child therapists for 8-10 years, 10% (n=2) reported being child therapists for five to eight years, 25% (n=5) reported three to five years, and 20% (n=4) reported 1-3 years. Zero percent of participants admitted to practicing for less than one year. If one were to consider "below five years" as being a "new" clinician, and "above five years" as being an "experienced" clinician, 45% (n=9) of participants are "new clinicians" and 55% (n=11) are "experienced clinicians" in the field of individual therapy with children.

Themes of race. Question 31 addressed the racial and ethnic makeup of the sample. Eighteen participants answered this question. This question presented participants with an extensive list of races/ethnicities to choose from and participants were instructed to select all races/ethnicities they believed they identified with. Many participants named more than one race or ethnicity. The following results are presented in terms of the highest percentages to the lowest percentages. Eighty-nine percent (n=16) of participants identified themselves as European American/White, 16.7% (n=3) identified themselves as biracial, multiracial or of mixed race, 11.1% (n=2) identified as African

American/Black, 11.1% (n=2) identified as Northern European, 11.1% (n=2) identified is Mexican, Mexican American or Chicano, 11.1% (n=2) identified as Latino or Latina, 11.1% (n=2) identified as East Asian, 5.6% (n=1) identified as South African, 5.6% (n=1) identified as Caribbean, 5.6% (n=1) identified as Southern European, 5.6% (n=1) identified as Middle Eastern or Northern African, 5.6% (n=1) identified as South Asian, 5.6% (n=1) identified as Southeast Asian, and 5.6% (n=1) identified as "Other." Ethnicities that were not represented at all by this sample, but were listed as options of choice included: East African, West African, Central African, American Indian or Alaskan Native, and Pacific Islander.

 If racial or ethnic identity are at all predictive of the ways in which clinicians choose to respond to child clients, conceptualize their theoretical orientation or process feelings in such situations, then this study's data would be largely skewed towards the European American/White understanding of this concept. Because the number of participants in this survey was fairly low and the number of participants that did not identify as European American/White were fairly low, it is difficult to make meaningful conclusions about how the participants' responses might correlate with those of others of the same demographics, and far less easy to know how representative their ideas would be of persons of other ethnicities.

Themes of gender. Question 32 addressed the genders represented by this sample. Twenty participants answered this question. Ninety-five percent (n=18) of individuals identified as female, five percent (n=1) of participants identified as male, and five percent (n=1) of participants identified as gender queer, gender fluid or gender non-

conforming. There were no participants who did not identify with one of the genders listed or chose "other."

If gender is at all predictive of the ways in which clinicians choose to respond to child clients, conceptualize their theoretical orientation or process feelings in such situations, than this study's data would be largely skewed towards the "female understanding" of this concept. Because the number of participants in this survey was fairly low and the number of participants that do not identify as female were very low, it is difficult to say how representative their responses would be of females in general, and less easy to generalize from the five percent of gender queer, nonconforming, or fluid, and equally less easy to imagine how representative the five percent of males' responses might be of male clinicians overall.

Themes of theoretical orientation. Question 33 addressed the theoretical orientations of the participants. Twenty participants answered this question. Participants were asked to select all of the orientations they believed they utilized in their own practices. The following results are presented in terms of the highest percentage to the lowest percentage. Sixty percent (n=12) identified as using psychodynamic theories to inform practice, 60% (n=12) selected Cognitive Behavioral Therapy practices, 30% (n=6) selected Dialectic Behavioral Therapy, 30% (n=6) selected Behavioral Therapy, 30% (n=6) selected Intersubjective or Relational theories, 20% (n=6) selected "Other" orientations (when asked to identify these, answers included: Family, Reflective, Narrative, Integrative and Perspective), and 10% (n=2) selected Psychoanalytic practices.

It seems as if these numbers are fairly diverse and do not suggest an overwhelming presence of one theoretical orientation, even in this fairly small sample.

Themes of parenthood. Question 34 asked participants to note whether they had children of their own. Twenty participants answered this question. Sixty-five percent (n=13) of participants indicated that they did not have children of their own, and 35% (n=7) indicated they did have children of their own.

Below is a table of demographic data.

Table 1

Demographic Characteristics of Participants

Years of Experience	Less than 1 year	0% (n=0)
	1-3 years	20% (n=4)
	3-5 years	25% (n=5)
	5-8 years	10% (n=2)
	8-10 years	5% (n=1)
	More than 10 years	40% (n=8)
Race	African American/Black	11.1% (n=2)
	South African	5.6% (n=1)
	Caribbean	5.6% (n=1)
	European American/White	88.9% (n=16)
	Northern European	11.1% (n=2)
	Southern European	5.6% (n=1)
	Mexican, Mexican American, Chicano	11.1% (n=2)
	Latino/a	11.1% (n=2)
	Middle Eastern/North African	5.6% (n=1)
	South Asian	5.6% (n=1)
	Southeast Asian	5.6% (n=1)
	East Asian	11.2% (n=2)
	Biracial, multiracial, mixed race	11.2% (n=2)
	Other	5.6% (n=1)

Table 1 Continued

Gender	Female	95% (n=18)
	Male	5% (n=1)
	Gender queer, gender non-conforming, gender fluid	5% (n=1)
Theoretical Orientation	Psychodynamic	60% (n=12)
	Psychoanalytic	10% (n=2)
	CBT	60% (n=12)
	DBT	30% (n=6)
	Behavioral	30% (n=6)
	Intersubjective, Relational	30% (n=6)
	Other	20% (n=4)
Children/No Children	Yes – Has children	35% (n=7)
	No – Does not have children	65% (n=13)

Analysis of Other Significant Quantitative Data

Other important quantitative data addressed the settings in which clinicians practiced, the resources participants used to discuss both their countertransference and their feelings regarding the "I love you" situation, and the level of anxiety that participants reported after the statement of "I love you."

Settings of practice. Question three asked participants to identify the setting in which the interaction of "I love you" occurred. Twenty-six participants answered this question. The following results are listed from highest percentage to lowest percentage. 46.15% (n=12) of participants reported "the exchange" occurred in a public agency, 26.92% (n=7) selected private practice, 19.23% (n=5) reported "other" (which includes

non-profit, home outreach, and home visits), and 7.69% (n=2) of participants selected a school setting.

Resources and supports used by clinicians. Question six asked participants to select the resources they used to discuss their countertransference towards their child client. Twenty-one participants answered this question. Participants were asked to select as many resources as they felt applied and many participants chose more than one resource. The following results are listed from highest percentage to lowest percentage. Fourteen participants (66.7%) reported they spoke about their countertransference in primary supervision, 42.86% (n=9) reported peer supervision, 33.33% (n=7) reported using secondary supervision, 14.29% (n=3) selected "other" (including using the therapy of the therapist, group supervision, and a psychoanalyst), and 9.52% (n=2) reported they did not use any resources to discuss their countertransference at all.

Question 14 asked participants to identify the resources they used to discuss and process the situation in which their client said "I love you." Twenty participants answered this question. Participants were asked to select as many resources as they felt applied and many participants chose more than one resource. The following results are listed from highest percentage to lowest percentage. Forty percent (n=8) reported using no supports to process this exchange, 40% (n=8) reported using primary supervision, 30% (n=6) reported using peer supervision, 30% (n=6) reported using secondary supervision, and 20% (n=4) reported using "other" resources (which included the therapists' therapy, use of clinical notes and a child psychoanalyst).

One might consider the large difference in this set of data vs. data that represent resources used to discuss countertransference – while only 9.52% reported not using any

resources to discuss their countertransference, more than four times that, 40%, did not use any supports to discuss this situation. Furthermore, while 66.7% reported using primary supervision to discuss their countertransference, only 40% reported using primary supervision to discuss this particular situation. While this could be for a variety of reasons (clinicians do not believe this situation is clinically significant, clinicians are ashamed to share this experience, clinicians feel this situation is "inappropriate" to share with a supervisor, etc), the difference in data suggests that clinicians interpret this particular situation as being either less important than countertransference, or more sensitive than countertransference.

Reported anxiety levels of clinicians. Question nine asked participants to rate their level of anxiety when their child client stated "I love you." Participants were asked to select one of the following choices: No anxiety, a little anxiety, "medium" anxiety, a lot of anxiety, or severe anxiety. Twenty-one participants answered this question. The following results are listed from highest percentage to lowest percentage. Eleven participants (52.4%) reported "A little anxiety," 19.0% (n=4) reported "A lot of anxiety," 14.3% (n=3) reported "Medium anxiety," 14.3% (n=3) reported "No anxiety" and 0% reported "Severe anxiety." If one were to consider "no anxiety" and "a little anxiety" as being a low level of anxiety to perhaps not affect the situation, and "medium anxiety" to "severe anxiety" as being clinically significant, 66.7% (n=7) reported low anxiety and 33.3% (n=14) reported clinically significant anxiety during this verbal exchange.

Below is a table illustrating the quantitative data described above.

Table 2

Quantitative Data Described by Participants (Setting of Practice, Supervision,

and Anxiety Levels)

Setting of Practice	Public agency	16.15% (n=12)
	Private practice	46.15% (n=12)
	School setting	7.69% (n=2)
	Other	19.23% (n=5)
Supervision Used Re: Countertransference	Primary supervision	66.7% (n=14)
	Secondary supervision	33.3% (n=7)
	Peer supervision	42.86% (n=9)
	Other	14.29% (n=3)
	None	9.52% (n=2)
Supervision Used Re: I Love You Interaction	Primary supervision	40% (n=8)
	Secondary supervision	30% (n=6)
	Peer supervision	30% (n=6)
	Other	20% (n=4)
	None	40% (n=8)
Anxiety Level of Clinician	No anxiety	14.3% (n=3)
	A little anxiety	52.4% (n=11)
	Medium anxiety	14.3% (n=3)
	A lot of anxiety	19.0% (n=4)
	Severe anxiety	0% (n=0)

Analysis of Qualitative Data

The following analyses of qualitative data will first quickly address the high

percentages of trauma and adoption/foster care amongst the children that are being

discussed in the narratives of participants. Following this brief explanation, qualitative

data will discuss themes in the countertransference of participants, the three categories of

ways in which clinicians responded to their child client's admittance of "I love you," the

themes of the ways in which participants believed the relationship or the therapy was

impacted the "I love you" exchange, and the themes that arose when clinicians discussed what they would have done differently if they could "redo" the situation or conversation. Each section will present percentages and frequencies of responses followed by example statements in responses.

Prevalence of trauma and foster care/adoption in clients. Question four asked participants to briefly describe the child they will be speaking about during the rest of the questions (the child who stated "I love you"). Of course, participants were asked to omit any identifying information. In this question, participants commonly described the age and race of the individual, perhaps highlighting the child's favorite activities or some general qualities the client possessed. It is notable that the clients described had a high percentage of trauma, and experiences with foster care or adoption. Twenty-two participants answered question four and provided a description of their child client. Of these 22 clients being described, eight (36.3%) had either been adopted or were in foster care, and an additional eight (36.3%) clients had significant trauma histories. Therefore, 72.7% (n=16) of children that were described had significant trauma histories, were adopted, were placed in foster care, or a combination of these three characteristics. Because trauma histories, adoption and foster care are all experiences that can be indicative of attachment or relational difficulties, I think these experiences are important to note. Of course, it is difficult to discern if this high percentage of trauma/adoption or foster care is indicative of the possibility that children with such experiences are more likely to tell their therapist they love them, or if clinicians are more likely to remember or choose to describe their treatment with child clients that have such histories.

Some examples of descriptions given by participants about child clients with

experiences of trauma, adoption or foster care in question four include the following:

> PARTICIPANT 1: The client was a 4 year old male with a significant
> trauma history related to attachment disruptions. He is generally cheerful
> and energetic, and very expressive. At the time, he was living in a foster
> care home while his sister lived in a kinship care home.

> PARTICIPANT 10: 8 year old child living in Colorado. Mom and
> boyfriend previously addicted to methamphetamines, dad chronically
> depressed and inconsistently involved. Lots of disruption in relationships
> because of parental mental health issues, substance abuse, jail, probation,
> social services involvement, etc. Inconsistent caregivers. Child was
> extremely friendly and loving with me and told me he loved me every
> session, sometimes multiple times.

> PARTICIPANT 16: A 7 yr old Caucasian girl, oldest of 3 children, who I
> see in weekly outpt dyadic tx with her mother. She has been extremely
> emotionally dysregulated at home, and shows some of this in my office.
> Performs well at school and with activities. Hx of family turmoil; mother
> has abuse and neglect hx and father has alcohol hx and anger management
> problems. Significant marital trouble and second child born 18 months later
> with serious developmental problems that have required a lot of focus and
> which make him very difficult to live with. Third sibling born several years
> ago.

> PARTICIPANT 28: A victim of severe physical abuse who was living in a
> foster care home.

Description of countertransference. Question five asked participants to describe

any countertransference they experienced towards the child client that told the participant

"I love you." A very fascinating point about this question is the degree to which the

question was skipped entirely. Five participants skipped this question entirely and two

participants dropped out of the survey during this question, perhaps highlighting a high

degree of clinician discomfort with disclosing countertransference. Overall, this question

yielded 15 responses. These responses varied greatly, but four themes occurred during

analysis of these answers. The themes are as follows: Denial of countertransference,

protective or maternal instincts, negative countertransference, and positive countertransference.

Denial of countertransference. Out of 15 responses, two of the participants (along with the five that skipped the question all together) reported not having any countertransference towards their client at all. If one were to include the five individuals that entirely skipped this question along with the two participants that denied countertransference, it then seems as if 35% (n= 7) of participants did not report any countertransference at all towards the client being discussed. This response, of course, is interesting, as it suggests, perhaps, a difference amongst an understanding of the definition of countertransference amongst participants, or perhaps a general degree of discomfort with the idea of one having countertransference at all. Examples of these answers include:

PARTICIPANT 4: I was not aware of any.

PARTICIPANT 7: None.

Perhaps also related to this theme, two participants answered this question by describing that the client "reminded" the participant of someone in particular – in both cases, childhood peers. Of course, in the classical understanding of countertransference, our feelings towards our clients often arise out of our own previous experiences with others. In both of these answers, however, the participants fail to take this classical understanding to the next, practical and applicable step, in which they would describe how they felt about the client, which was likely contingent on their experience with the person from whom the experience originated. I have coded these answers as also denying

countertransference, as while they have admitted to some sort of conscious feelings, they fail to describe them or their impacts. Examples of these answers are as follows:

> PARTICIPANT 18: Child resembled children with whom I went to elementary school.

> PARTICIPANT 20: This client reminded me of my best friend when we were younger.

Protective or maternal instincts. Seven individuals (35%) described having protective instincts for the child client being described, or feelings that the participant interpreted to be motherly. These answers appeared with explicit use of the term "protect" or feeling "protective" along with explicit use of feeling "motherly" or "maternal." I felt the need to group these two sorts of statements together as I felt they were directly linked – likely when individuals described feeling maternal, they also felt they were feeling protective or wanting to "take care of" the child at hand. I expected this sort of countertransference to be common, as it was emphasized in the literature and also in my own experience. Interestingly enough, while these sorts of instincts, especially "maternal" implied a sort of special bond or closeness characterized by some sort of love, 0 participants explicitly identified any "loving" feelings towards their client.

Examples of answers that were coded as including feelings of protective instincts or maternal instincts included:

> PARTICIPANT 17: This client drew out some protective instincts in me, as the client was coping with an intense custody battle and being exposed to very adult concepts.

> PARTICIPANT 24: I felt motherly toward client.

> PARTICIPANT 28: Feeling a "need" to change the family circumstances for this child.

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Negative countertransference. Five individuals (33.3%) identified feelings of countertransference that were interpreted as negative. In these sorts of explanations, the participant would describe themselves as "not liking" the child, or would use adjectives with clear negative connotation to describe the child. Four of the five individuals that evoked the use of "negative" or unappealing terminology to describe the child mediated such descriptions with feelings of sympathy or empathy ("I felt sorry for her") or other positive countertransference – more below. Examples of this sort of response include:

> PARTICIPANT 2: Wanting to protect her and take care of her. Often times she would also challenge me and I'd find myself annoyed or flustered.

> PARTICIPANT 10: I knew his behavior was due to disturbances in attachments and that he was overly friendly with people, but I think he also detected that I was a stable and nurturing caregiver and genuinely enjoyed my presence. I felt good to be able to make him feel good, so there may have been some secondary gains I got out of that relationship. Not sure that's exactly countertransference though.

Only once did the feelings of negative countertransference exist alone, without being "mediated" or "dulled down" by the influences of empathy or positive countertransference. This answer is appears as follows:

> PARTICIPANT 16: I made a note after my second session with her that I didn't like her, which was quite unusual for me to feel with a young child. I discussed this in supervision. She was very sassy with her mother in the waiting room and acted provocatively--grabbing cash from her mother's wallet and sticking in down her pants. She had a pseudo-sexualized air about her early in our work together and a dismissive stance toward authority.

Overall, this suggests an ability for participants – across the board – to identify the complexity of feelings as often being both negative and positive, but it also suggests a slight unwillingness for participants to allow for negative feelings to sit alone – perhaps this felt too "harsh" or "mean."

Positive countertransference. Examples of positive countertransference existed three times (20%) out of all 15 participants. Those responses that were coded or partially coded as containing "positive countertransference" used positive language to describe their child client, typically describing the individuals with desirable traits or language that suggested a degree of closeness or admiration. Interestingly enough, two of the three individuals who responded with language that indicated positive countertransference mediated the positive nature language that was clearly attempting to emphasize the boundaries that existed between the individual and the client. Examples of these sorts of responses are as follows:

> PARTICIPANT 5: Affection, admiration of his intellect, frustration with the chaos that surrounded his sessions (including frustration with his pushing boundaries of all kinds in my office).

> PARTICIPANT 9: I definitely had high positive regard for this child, but don't remember any inappropriate thoughts or feelings that crossed the boundary of the therapist-client relationship. I was proud of his progress and our successful work together.

It is also interesting to note that the only times this theme of boundaries (which will continue to be pervasive throughout) came up in this question were when the participant was also describing positive countertransference. In other words, the only times it seemed "necessary" for participants to emphasize "boundaries" was when the clinician was speaking about positive countertransference, or things they liked or enjoyed about the client. There was no mention of boundaries coupled with responses that indicated motherly or protective feelings or even negative countertransference.

The other response to this question that indicated positive countertransference was mediated with a degree of negative countertransference – which can be found above in the response of PARTICIPANT 10.

It should also be noted that while negative countertransference was noted in 35% of responses, positive countertransference was noted in only 20% of responses. In other words, it was less likely for a participant to use positive language to describe their client than it was for the participant to use negative language to describe their client.

Below is a table illustrating the difference of countertransference described by participants.

Table 3

Countertransference Described by Clinicians

Denial of Countertransference	35% (n=7)
Protective/Maternal Instincts	35% (n=7)
Negative Countertransference	33.3% (n=5)
Positive Countertransference	20% (n=3)

Clinicians' responses to "I love you." Question 10 is the question in this survey that most directly aimed to consider the research question at hand. This question specifically asked clinicians to describe, in strong detail, the ways in which they both verbally and non-verbally responded to their client when the client said "I love you." This question was answered by 20 participants with varied degrees of thoughtfulness and reflection. As individuals were given the option to answer this question a second time for a second client, three of the 20 individuals answered this question twice – resulting in 23 answers total. The responses to this question were easily coded into the following three categories: 1) Stating "I love you" in return, 2) Using language other than love to disclose the feelings of the therapist speaking, and 3) Responses that avoided naming the

therapist's feelings at all through dismissive or avoidant behaviors. The prevalence of responses to question 10 that indicated use of language that emphasized boundaries will also be discussed in this section.

Stating "I love you" in return. Four (17.3%) of the 23 answers to this question indicated that the clinicians responded to their child clients' saying "I love you" by choosing to say "I love you" to the client in return. Only responses that explicitly used the words "I love you" were coded into this category. While it does not seem that any other questions directly correlate to clinicians being more likely to state "I love you back," it is noticeable that while only four participants in the survey identified as being child therapists for 1-3 years (the shortest amount of time represented by survey participants), three of these individuals were coded into this category. The following are examples of some of these responses to question 10:

> PARTICIPANT 1: said "Thank you, [client's name]. I love you too." I can't remember precisely what I said, but I explained to him that parents love kids in a very big way and that teachers and therapists love kids too but differently from how parents love kids, and I reflected to him that he might be feeling very sad about missing his mommy but that there are many adults in his life who love him.

> PARTICIPANT 27: Immediately, I said "Thank you!" But then I said "I love you too!"

Two of the clinicians who responded to their clients with "I love you" responded quite thoughtfully and extensively to question 28 (which asked clinicians what advice they might offer to young clinicians in a similar situation). It seems as if these two clinicians used question 28 to explain their choice response and the reasons behind their thinking. Below are those two answers:

> PARTICIPANT 1: Every situation is different and you need to use your best clinical judgment about how your response might impact that child's

sense of self and sense of self in relationship to caring adults. Kids need to feel loved and when they experience a loving relationship with a caring adult particularly when they are struggling to experience that in identified attachment relationships, their minds aren't equipped to understand the nuances of differences in relationships with parents vs. teachers vs. therapists.

PARTICIPANT 14: Embrace your feelings. Observe them. Recognize that loving a client may be a natural feeling given the depth and level of work you do with them. Hopefully, we care for our clients and after time, we may grow to love them too. That's OK and natural. It doesn't mean we replace their parents, or that we will "act out." Of course, if this is expressed during the first few sessions to the clinician, something is not "right" and you want to think about boundaries, but if you've been working for a year, several years with a client and closely with them and love comes up, I think it OK to embrace that feeling, should you feel it for the client. It's Ok to feel feelings. Don't fear them.

It is certainly interesting how these two responses complement each other: while PARTICIPANT 1 emphasizes the importance of considering the feelings of the child at hand (needing to feel loved, struggling with attachment, fostering the child's sense of self), PARTICIPANT 14 emphasizes the feelings of the therapist (as the response notes that loving feelings are natural and okay to explore and disclose). While emphasizing different "sides" of the dyadic relationship, both responses stress how love can simply and naturally arise in the relationship between child and client, and how these feelings, if disclosed, can positively effect the relationship instead of complicate it.

Use of alternative language to disclose. Six (26%) of the 23 answers to this question indicated that the clinicians responded to their child clients by using language alternative to the word "love" to disclose their own feelings towards the child client. It is possible that the alternatives were used in order to "water down" the therapist's response because a flat "I love you also" would be too uncomfortable for various reasons. Five out of six of these responses used the word "care." As part of using alternative language to

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love, all of the therapists in this category exhibited a response to the child that involved

some sort of self-disclosure on the part of the clinician. The following are examples of

some of these responses:

> PARTICIPANT 2: I sat with client, at her level, looked her in they eyes. I thanked her, told her that I cared a great deal for her and focused on content and meaning of her words as opposed to actual words. We had worked together for many years.

> PARTICIPANT 3: Put one arm around her as she was hugging me then bent down to say something like 'you want me to know how much you care about me. I care about you too.' I think we also reviewed how hugs should be asked for first (to make sure the other person wants a hug too).

> PARTICIPANT 4: It felt quite natural to be told that after working with a child in his home weekly for that length of time (about 7 months). I had worked in a Montessori school in my past and also done some other work with children so this sort of scenario was not that unusual to me, though I realize that therapy had its own areas of boundaries that some other professions do not. I made eye contact and tried to show him that I honored what he said to me. I said thank you. I think it's very important to validate and not minimize these feelings in children and to honor the relationship that is formed during therapy -- as well as treat a child with respect. I can't remember exactly what I said in response, but it was to the effect that "And I care about you, -------. You and your wellbeing are important to me. I am excited by all the work you have done (such as learning to get along better in school) and how well you're doing. I really have enjoyed our times working together." I tried to show that the child was important to me, that I did care about him and how he was doing, and then tried to have him focus on his own empowerment and progress and effort and how he was improving his life through taking these steps to change his thoughts and behaviors.

> PARTICIPANT 9: I believe I did not say it back, but said something else positive to try to avoid hurting his feelings. He gave me a brief hug, which I allowed, and told him he did a great job in therapy and that I really enjoyed working with him.

Three individuals who were coded as using "substituting language" for disclosure

chose to emphasize the important of not "fearing" or "over-dramatizing" a child client's

explicitly stated transference of "I love you." I thought this particularly interesting, as the

responses of these individuals clearly indicated an avoidance of the child's chosen

wording ("love"). Some of these responses also emphasized the importance of not

hurting the child's feelings by responding with "something positive" that focuses more on

the intent of the words than the words themselves. Examples of question 28 responses for

this category of responses to question 10 are as follows:

> PARTICIPANT 2: Pay attention to context and the motivation, intent, need behind the words as opposed to just the words. Don't be frightened by them, a kid is sharing something depending on their history and relationship with you and others.

> PARTICIPANT 4: I think the main thing is to realize that children spontaneously and naturally express these feelings of love for caretakers, teachers and other professionals like therapists, and to not dramatize or make too much of it, to show honor and respect to the child and to validate and not minimize their feelings, and to not act shocked or afraid of their statements. I think it's helpful to say something positive in response that shows one is validating them, and also to authentically point to what one can say ethically--that a child one works with is someone important, that one chooses to work with and one wants to see succeed and be happy in life. Also if it can be said authentically I think it never hurts to share with the child something valuable one has learned from them or that they have added positively to one's life, such as helping one have a pleasant day or teaching one about some quality or strength through their own modeling. I think the main focus of the response should be to empower the child to a state of inner strength and wholeness and self-love versus dependence on the therapist. I did not do this in this situation, but there may be some cases where it is helpful to process further with the child his or her feelings to what it feels like to say "I love you" to the therapist or other people in their life, and to find out what this might mean to them – i.e.; is it natural and spontaneous affection or is it stemming from a fear or anxiety, or a need for finding security?

> PARTICIPANT 7: These words don't have to be scary, especially from young and vulnerable children. Our anxiety could cause them to feel shameful about their caring feelings toward us, so we have to be careful to not hurt them.

   Dismissive or avoidant responses. 13 (56.5%) of the 23 answers to this question

indicated that the clinician responded to their child client by choosing not to disclose any

of their own feelings towards the client and were either dismissive or avoidant of the statement all together. It is important to note that this was the category that the majority of responses fell into. These responses did largely vary – while some responses included a verbal response that acknowledged the statement in some way (without disclosure), other responses included a verbal response completely unrelated to the statement, and other responses did not include any verbal communication at all.

The following are examples of dismissive/avoidant responses that included a verbal acknowledgement of the statement:

> PARTICIPANT 10: I would usually reflect "you're feeling loving right now." There were 2 times when I talked to him about how I was a special person in his life, and happy that he had loving feelings for me, but I wanted him to remember that we were only going to be friends for a short time in life, just while I was working on him having a more loving relationship with his mom.

> PARTICIPANT 12: Thank you, that is so sweet of you to say, Nonverbal- gave a smile.

> PARTICIPANT 17: I maintained eye contact with the client and said, "that's a very kind feeling to share. It tells me that you feel safe talking about hard things here."

> PARTICIPANT 18: Thanks, buddy.

> PARTICIPANT 28: …sounds like you have some strong feelings towards me; can you tell me more about how you are feeling?

The following are examples of dismissive/avoidant responses that included a verbal response but without acknowledgement of the statement:

> PARTICIPANT 6: "I'm looking forward to seeing you at our next meeting."

> PARTICIPANT 20: "I know it's hard saying goodbye and we had a lot of fun these past couple of months… ." I redirected the child.

PARTICIPANT 25: Had a very good session when client opened up about true feelings about her home life. Mom was present when client said "I love you," and I smiled sincerely and said that I looked forward to seeing them next week. It didn't happen again so I didn't think it was a big deal worth mentioning later. I would have addressed this if this continued week after week.

The following are examples of dismissive/avoidant responses that did not include a verbal response at all:

PARTICIPANT 6: Often times, mother did not give me a chance to respond. She would say something like "____ is your counselor and I know you really care for her." There were other boundary issues, too, which we addressed, such as the child trying to kiss me upon leaving. In those instances, I supported mother in reinforcing what types of people get kisses (family), hugs (friends, other professionals--teachers, CASA workers, CPS workers, etc.) and smiles (neighbors, other children, people we are not sure parents know, etc.).

PARTICIPANT 22: Hugged the child. No verbal response.

Correlating responses from this category in question 10 to responses from question 28 varied a great deal. Some responses focused on encouraging the therapist to allow for the child to "explore the feeling more." or asking the children to explain how they experience love, etc. Other responses focused on "displacing" or separating the love from the therapist, allowing it to exist only as affection towards "the relationship." or towards someone whom the therapist might represent. Below are examples of responses in which the therapist seemed to justify their avoidant or dismissive responses by explaining that they interpreted the love not to be for the therapist, but more so, to the relationship or another object.

PARTICIPANT 12: Not to take it personal, it's something about the connection they made with you; you may have modeled something to them that lead them to express that emotion; however, it's not like they love you 'Be my mommy,' its more of I love you because you gave me a safe place to just "be" or process. It's really not about you, but more about them expressing intense happiness towards something you provided to them.

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PARTICIPANT 16: This kind of comment from a child could mean many different things, depending on the child and the therapeutic context. But, I would certainly say not to be afraid of the comment or that it means inappropriate boundaries on the therapist's or necessarily the child's part. Children can be more open with these kinds of statements than adults and feelings of love are an understandable and important part of the work. I have a puppet helper and sometimes even older kids are free to say "I love you" to my puppet alter-ego (as well as strangle him/her!). I recommend that child therapists work with a puppet so that some of the feelings can be displaced and worked out that way. I also think it's important to sort out one's countertransference reactions. The ability to cherish and enjoy the warmth and closeness of the connection (if indeed that is what the 'I love you' comment is about--it could be veiled anger, performance, seductive, etc) is important as well as not to move into an overly gratifying relationship.

Both of these types of responses – responses that encouraged the child to explore the feeling more, and responses that interpreted the love as not necessarily being "love," or not even being feelings for the therapist – both point to an important part of the dismissive/avoidant response model: that therapists divest themselves of their own feelings, but also, that they empty themselves of the idea that feelings of love could ever be realistic—that is, deriving from the real relationship – rather than simply transferred upon them.

Perhaps as is already noticeable in the previous response examples, many of the ways in which individuals chose to respond to their clients' admissions were with a review of boundaries. Six of the 23 responses (26%), included a review of boundaries. This sort of review existed across the board in all other categories. In other words, even when individuals responded to the client with "I love you, too" boundaries were also reviewed. This review of boundaries also varied and was illustrated in a few different ways. Some clinicians emphasized a review of physical boundaries (hugging, sitting on laps, etc), while some versions of this review emphasized the "different" nature of the

therapeutic relationship – that it is temporary, and "not the same thing" as other loving

relationships. Some examples are as follows:

> PARTICIPANT 1: said "Thank you, [client's name]. I love you, too." I can't remember precisely what I said, but I explained to him that parents love kids in a very big way and that teachers and therapists love kids, too, but differently from how parents love kids, and I reflected to him that he might be feeling very sad about missing his mommy but that there are many adults in his life who love him.

> PARTICIPANT 3: Put one arm around her as she was hugging me then bent down to say something like 'You want me to know how much you care about me. I care about you, too'. I think we also reviewed how hugs should be asked for first (to make sure the other person wants a hug, too).

> PARTICIPANT 10: I would usually reflect "You're feeling loving right now." There were 2 times when I talked to him about how I was a special person in his life, and happy that he had loving feelings for me, but I wanted him to remember that we were only going to be friends for a short time in life, just while I was working on him having a more loving relationship with his mom.

It is interesting that this issue of boundaries comes up with clinicians across the board in

terms of responses. It emphasizes how many clinicians believe that strong feelings (such

as those of love, care, etc) have the potential to cross the boundaries that we have created

and that we feel so loyal to.

Below is a table illustrating the different ways clinicians responded to their child

client.

Table 4

Clinicians' Responses to the Child Client's "I love you"

Stating "I love you" in Return	17.3% (n=4)
Use of Alternative Language to Disclose	26% (n=6)
Dismissive or Avoidant Responses	56.5% (n=13)

Impact of responses. Question 12 of this survey specifically asked clinicians to identify the ways in which the therapeutic relationship, or the therapy itself, was impacted by the clinician's response to "I love you." This question was answered by 20 participants with varied degrees of thoughtfulness and reflection. As individuals were given the option to answer this question a second time for a second client, three of the 20 individuals answered this question twice – resulting in 23 answers total. These responses were coded into the following three categories: 1) No effect at all, 2) Positive effects, and 3) Negative effects.

No effect. Ten of the 23 responses (43.4%) to this question described that the therapist believes there were "no changes" to the therapy or the therapeutic relationship after the clinician's response to "I love you." Many of these questions were very limited in depth – often simply reporting "No" or "N/A." Some individuals also reported they were not sure if there was an impact, or they remained ambivalent about the appropriateness of their chosen response – sometimes stating "I don't think so" or "I do not believe it affected the relationship." One participant (PARTICIPANT 10) described "I did feel confused about if I had done the right thing and guilty." Two of these responses also diverted the attention away from the client and the client-therapist relationship and took some time to consider how the relationship impacted the caregiver (which the question, specifically, did not allow space for). For example:

> PARTICIPANT 6: don't believe that the it affected the child-therapist relationship, but I do believe that it deepened the parent-therapist relationship with the child's mother as it helped me explore with her the meaning and feelings towards the therapy services being provided and the therapeutic relationship.

Positive effects. Ten out of 23 responses (43.4%) reported that the therapists believed the way in which they responded to their client's admission of "I love you" positively affected the therapy and the therapeutic relationship. Most of these responses described that the clinician believed the relationship became more "authentic" more "open," and perhaps more "affirming." Some of the examples of "positive changes" responses to question 12 include the following:

> PARTICIPANT 2: Yes, it allowed for the relationship to be honored as real and allowed for feelings around ending to be authentic.

> PARTICIPANT 3: I think it was helpful to set some healthy boundaries with her to show her that when people care, they are respectful of how things make the other person feel. And I don't think she felt rejected by me so I don't think there were adverse effects.

> PARTICIPANT 7: I think it was a signal that he had found my presence supportive and loving for him and his father. This positive relationship led us to do great work together.

> PARTICIPANT 17: I knew that I needed to maintain an even, consistent presentation with this client during my response. The client appeared to respond well to this, and ultimately was able to work through the transference she experienced and have a healthy resolution.

The likelihood that clinicians claim the relationship was positively affected does not necessarily correlate to the ways in which clinicians responded. In other words, clinicians who were dismissive or avoidant in their responses believed their work was positively affected, as well as clinicians who responded with "I love you too" or a substitution of words for some disclosure. This is very interesting – as it seems clinicians believe they positively affected the relationship regardless of the ways in which they responded. If this is true, and clinicians interpreted changes in a way that is unbiased (unlikely) and accurate, the results of this exchange does not necessarily accelerate or impede the success of therapy.

Negative effects. Only one response indicated that the therapist believed their response had negative effects on the child's therapy. This individual chose to respond to the client's "I love you" with a response that was dismissive and avoidant. This individual described that s/he believed the child felt as if the therapist was being "withholding" by not responding to the admission or disclosing any personal feelings. Below is this response:

> PARTICIPANT 5: I'm not sure. I think he felt that I was being withholding, and because he became so hyperactive (a usual experience, but probably exacerbated by the sexual tone he had, and the boundary crossings) it was hard to make sense of the words "I love you."

Below is a table illustrating how clinicians feel their response to "I love you" has affected the therapeutic relationship, the child, or the therapy.

Table 5

Perceived Effects of the Clinician's Response

No Effect	43.4% (n=10)
Positive Effects	43.4% (n=10)
Negative Effects	4% (n=1)

"What I would do differently…" Question 13 of this survey specifically asked clinicians to identify how they might have reacted to the child's admission differently if given a second chance. This question was answered by 20 participants with varied degrees of thoughtfulness and reflection. As individuals were given the option to answer this question a second time for a second client, three of the 20 individuals answered this question twice – resulting in 23 answers total. These responses were coded into the following 3 categories: 1) "I would do nothing differently," 2) "I am not sure," and 3) "I would do something differently" (which includes a few different ways of re-imagining the situation).

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Nothing different. Twelve responses out of all 23 (52.2%) indicated that there is

nothing they would do differently in the situation if given the opportunity. Most of these

responses were quite limited in depth and vague – usually consisting of a simple "No."

Similar to results in the previous section – the way in which the participant responded to

this question does not seem to be impacted by the way in which the participant responded

to the child's admission.

"Not sure." Five responses out of all 23 (21.7%) indicated that they had some

ambivalence about the way they chose to respond, and that they maintained a level of

uncertainty about "the best answer." Two examples of these responses are as follows:

> PARTICIPANT 1: No- I wouldn't have known what to do differently and I
> still don't know the best way to respond to that statement for a child with
> an attachment-related trauma history.

> PARTICIPANT 9: I'm not sure, it is still an issue that I feel ethically
> unclear about. I don't think this client was hurt, or even particularly
> noticed that I didn't say "I love you" back, and it did cause me to examine
> my discomfort. I'm not sure what I would do if it happened again.

These particular responses honestly address the difficulty of such a situation and clearly

illustrate the lack of guidance that even seasoned clinicians experience in regards to this

topic. The disclosure of "I am not sure what to do about this." and "I don't know what is

right or best" is an honest statement that seems to reflect a willingness to be self-

questioning and thoughtful.

Something different. Six of the 23 responses (26%) indicated that the clinicians

would do something differently if they were given another chance, or if they were ever

met with this situation in the future. These responses varied in terms of what exactly the

clinician states they would do differently. Three of these six individuals described that

they would change the way they worked with the caregivers of the child client. Two of these responses are as follows:

> PARTICIPANT 10: Looking back, I probably could have been more effective at helping him take the loving feelings to his mom, and guiding her in how she reacted to him.

> PARTICIPANT 16: I would have checked in with Mom sooner about her reactions

One of the individuals cited a wish that more supervision had been possible, or that there had been opportunities to "talk about" the situation more with others. One of the individuals also cited a wished that s/he had offered the client more time to express and elaborate upon their loving feelings towards the therapist (but did not state a wish to disclose the therapist's own feelings).

One individual described a wish to have been more honest and open with her/his feelings towards the client – using the word love instead of a substitute – caring. This individual writes:

> PARTICIPANT 5: [I] would have used her words "love" rather than defensively shifting my language to the word "caring." She is a child with vulnerable feelings, and I fear that my shift in language was an enactment - in which her love/the intensity of her love/fears is met with distancing rather than a "real" engagement.

This individual's strong response honestly highlights something that was surprisingly missing from all other responses – a wish to fully disclose love to the child instead of masking such a strong feeling with important, but undeniably "duller" feelings of care. The participant in this case makes a remarkably honest statement that the shift in language was defensive, though without saying what anxiety was being warded off in this defense. PARTICIPANT 5 points out that her client had "vulnerable feelings," and that the masking of "love" could have been an enactment. With such a high percentage of

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children with trauma, adoption and foster care experience in the population being discussed – I imagine that the "vulnerable feelings" that PARTICIPANT 5 mentioned were quite common amongst the children mentioned in these responses. PARTCIPANT 5 also goes so far to offer that a masking of love could be an enactment. In saying this, it seems that PARTICIPANT 5 realizes that children with strong histories of trauma, adoption, foster care, etc, likely do not have a strong understanding of love as being positive, or as themselves being loveable. As this participant wonders – was denying her love for her client only furthering enforcing the idea that the child client already had – that she was unlovable?

Below is a table illustrating if participants would have "changed" something about their interaction if that were possible, or if they would react differently moving forward.

Table 6

Clinicians' Description of Choosing to Interact Differently in the Future

Nothing Different		52.2% (n=12)
"Not Sure"		21.7% (n=5)
Something Different		26% (n=6)
	Change caregiver interactions	(n=3)
	More supervision	(n=1)
	More honesty	(n=1)

A Deeper Understanding of Three Cases

The following section will focus on the answers of three participants in the study – PARTICIPANT 1, PARTICIPANT 4, and PARTICIPANT 10. The responses of these participants were chosen because of their depth of reflection and the dynamic nature of their cases presented – which highlighted a number of common issues and interests. The

reflections of these three participants will be considered below, which could allow for the reader a more comprehensive understanding of the sort of depth this survey often lead to, and some more concrete examples of how this "I love you" exchange might actually occur in therapy.

Participant 1. Participant 1 is a white, gender queer, gender fluid or gender non-conforming individual with 1-3 years experience working as a child therapist. Participant 1 does not have any children, and employs Intersubjective, Relational, Behavioral, and Psychodynamic theories into clinical practice, along with influences of DBT and CBT. Participant 1 practices at a school, where the participant was met with a four year old client. Participant 1 describes this client as "cheerful and energetic, and very expressive." This client is four years old with "significant trauma history related to attachment disruptions." This client is also currently separated from his sister and living in foster care.

Participant 1 describes that the "I love you" interaction occurred when the child was writing "I <3" on a white board, and listing the names of a variety of female caregivers. Unresponsive to questions about this process, the child was continuing to ignore the therapist's attempts at ending the session when the child stated "I love you. Do you love me?" With such a high degree of directness that other children seem to lack in their admission, the client clearly asks for a response that cannot be met with a subject change or complete avoidance of the statement. The directness of this specific child makes me wonder if all other children are implicitly and silently also asking "Do you love me?" each time they tell someone that they love them. With such an inescapable need to respond, this statement and the question that followed provoked "a lot of anxiety"

from the therapist, who chose to respond with "Thank you, [client's name]. I love you too." The therapist then went on to explain how while it is true that the therapist loves the client, it is important to note that the therapist does not love the client in the same way that parents might love their children, or how a teacher might their students. The therapists also writes "I reflected to him that he might be feeling very sad about missing his mommy but that there are many adults in his life who love him."

Later, the participant justifies and explains the response given by writing "Kids need to feel loved and when they experience a loving relationship with a caring adult particularly when they are struggling to experience that in identified attachment relationships." Despite the clarity of this belief that children "need to feel loved" (especially when they do not experience much love in their lives), the therapist continues to feel conflicted about the response given – feeling unsure if the right choice was in explicitly returning the feelings of love, writing "I still don't know the best way to respond to that statement ["I love you"] for a child with attachment-related trauma history."

In interpreting the above responses from participant 1, it is clear that the therapist had strong feelings – likely of love – for the child, and that the offered response was beautifully authentic and honest. The therapist also alludes to the idea that the child client existed in the therapist's mind beyond sessions, and the therapist used a personal therapy to discuss possible countertransference feelings for the child and the situation in which the two admitted their love for one another. It is also interesting that the client chose to not bring this interaction to primary, secondary or peer supervision, suggesting a level of shame or embarrassment that is compounded by the therapist's admission of felt

insecurity about the offered response. I wonder how the therapist's strong (and, as discussed above, rare) response influenced the level of anxiety about the situation, and if the therapist's anxiety and insecurity caused the therapist to follow up the "I love you" with a review of appropriate boundaries and interpretation of different "types" of love the client may know. It is also striking that the therapist is "not sure" about the effects the interaction may have had on the relationship. While the therapist does note positive changes that occurred during the course of therapy (the child became more engaged in therapy), the therapist is hesitant or resistant to interpret that this could, perhaps, be because the child understood that the therapist loved him. The therapist, instead, imagines that the therapy was intensified by the client's admission that he missed his own mother. I wonder the degree to which this is true, or if this statement is affected by the therapist's insecurity in the offered response, and an underlying unwillingness to admit that the therapist's love could be appropriate and also transformative.

Participant 4. Participant 4 is a white, South African, Northern European and Southern European female with 5-8 years of experience working as a child therapist. Participant 4 does not have any children, and typically employs CBT, DBT and narrative therapy influences in therapy work in a public agency. In this public agency, participant 4 began working with a 9-year-old African American male in his own home. The therapist describes this client as a "male who loved arts and theater and had some challenges with being bullied by other children." The therapist notes she us unaware of any countertransference towards this child.

The participant describe that the "I love you" interaction occurred during an in-home session. The therapist describes that the child spontaneously told the participant "I

love you," which produced "a little" anxiety on the part of the therapist. The participant describes that she feels this was a normal development at this time in the therapy. She writes that they two had been working together for about seven months, and that it seemed like an appropriate time for the child to disclose this feeling. While the participant commented that this situation was not unusual or new to her, she describes that she feels therapists have "boundaries that some other professions do not." The therapist described that she felt a strong need to validate the child, express understanding, and make a conscious attempt to not minimize the situation. The participant describes that she responded to this patient with a response that disclosed her own feelings, but did not use the word love. The participant stated, "And I care about you, -------. You and your wellbeing are important to me. I am excited by all the work you have done (such as learning to get along better in school) and how well you're doing. I really have enjoyed our times working together."

Participant 4 goes on to describe that she believes her response was a clear affirmation of respect and trust, and describes that there was no negative impact of the interaction. Interestingly, the participant describes that she believes the therapist should not "dramatize" the response, but should "show honor and respect to the child to validate and not minimize their feelings." The participant also adds that she believes there are ethical limitations in this situation that determines what the therapist "can say." The therapist also seems to have some anxiety about ensuring that the therapist's response does not enforce or instill a "dependence on the therapist," but instead focuses on fostering feelings of "self-love" for the client.

In interpreting the responses of participant 4, I am struck by the therapist's need to ensure a validation and lack of minimization – but I am interested that she does not understand her decision to substitute "care" for "love" as an invalidation and minimization of the child's feelings. Unfortunately, participant 4 does not directly name why she chose not to use the word love, nor did she describe how she authentically felt about the child being described. In fact, the participant denies any countertransference at all. I am also struck by the participant's explanation of instilling "self-love" vs. "dependence." I think this is an interesting explanation as it seems somewhat developmentally inappropriate. While 9 years old may be in the beginning phases of developing a sense of self-confidence or self-love, to expect a lack of dependence during such a young age seems to be denying the child an experience of positive dependence, and it also seems to be equating "love" to "dependence." – an interesting question that, unfortunately, goes unexplored.

Participant 16. Participant 16 is female with more than 10 years of experience working as a child therapist. This participant did not identify her race or ethnicity. Participant 16 does have children of her own and typically employs Psychodynamic theories to influence her private practice. This participant describes her experience with a 7-year-old white girl who is in treatment with her mother. The child has a history of "emotional dysregulation," and some family difficulties, as the child's mother has history of abuse and neglect and the child's father has "anger management problems" and a history of alcohol abuse. The therapist is honest in describing her countertransference, noting that she initially did not like child client. She notes she experienced her as "sassy,"

and sexually provocative with a "pseudo-sexualized air" and having a "dismissive stance towards authority."

This participant focuses a great deal on the relationship with the client's mother. The participant describes that she believes the mother experiences her as "an ally" or a "mother figure," which is somewhat complicated by the reality that the child client can often be very "mean" to her mother. The therapist describes that she has some unanswered questions and curiosity about how the mother experienced the love that the child expressed to the therapist during sessions. The therapist describes that the child often stated, in front of the mother, that she wanted to "stay here forever" and "all the good is here and the bad is at home." The client tells the therapist that she loves her in a note that is passed along at the end of a session. The therapist read the note out loud, and did not respond, but instead smiled at the child and at her mother. At this time, the therapist notes a change in the countertransference – as she develops some feelings of "warmth and tenderness." The therapist notes she interpreted the client's admission as being related the "maternal holding environment" that the therapist had attempted to foster in sessions. When the patient gave the therapist a second note, telling the therapist that she loved her, the therapist responds by letting the child note she will keep the note with the first note, but does not acknowledge the feelings of love or her own countertransference.

In interpreting this participant's responses, I am struck by the attention the therapist pays to the mother's responses and feelings about the situation. The participant writes, "I am planning to talk to Mom about Mom's reactions to it. This is a girl who can be very mean and rude to her mother, telling her she hates her, so I wonder what it stirs

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up in Mom to have her be loving toward me." I wish I could know if this participant ever had this conversation, and how the discussion went. This process brings up some interesting questions about the complicated process of "loving the therapist" but "hating the mother." Although the participant does not explicitly state this, I wonder if there are some underlying feelings of competition in this triadic relationship – how does the therapist feel to be the one that is loved, and how does the mother feel being the one that is hated? How might this mirror the child's Oedipal complex (which was at the forefront of the child's life only a few years ago). I wonder how this might have influenced the therapist's change in countertransference during their relationship, and I also wonder how the child client interprets the feelings that are arising between the mother and the therapist.

Conclusion

This concludes the quantitative, qualitative and sample narrative analysis of this study. The following chapter will allow for discussions of the preceding findings.

CHAPTER V:

Discussion

To review, the purpose of this study was to consider the ways in which clinicians respond to explicitly stated love from child clients – namely, how clinicians respond when their child clients state "I love you." In considering how clinicians choose to respond to this statement, the research also aimed to consider why clinicians choose to respond in whatever way they do, and also what are the effects of such responses on the child, the therapist, and the relationship?

Because this was the first (at least, known to me as the researcher) study of its kind, there are not any findings to compare to. That is, it is impossible to say if this study has confirmed findings of literature or other similar studies because there is no literature that examines such a question and there have been no previous studies of this kind. Still, there remains much to discuss about the findings of this study, especially in terms of how the findings relate to the literature and how they may affect research and practice in the future.

This chapter will allow for space of a discussion of the findings previously described in **CHAPTER IV – Findings**. This chapter will mainly focus on some interpretations of the data presented in the findings above, and will conclude with some suggestions for further research and possible improvements for this particular study. The "major" findings of this study are largely related to common countertransference reactions towards a child client, the ways in which clinicians responded to child clients'

statements of "I love you," and the ways in which clinicians believe their responses affect the relationship.

Common Countertransference to Child Clients

It was difficult to find literature that specifically addressed the common countertransference reactions towards child clients, but the findings of this study, in terms of countertransference, confirm many findings related to countertransference. Primarily, literature related to the "rescue fantasy," and literature regarding hate vs. love in the countertransference inform a discussion of countertransference towards child clients.

The findings highlight a fairly high degree of "maternal" or protective instincts that often arise when a clinician is working with a child client. In question five, seven (35%) of participants admitted to countertransference that took the form of some maternal or protective instincts. These participants often commented that they felt "motherly" towards the child client, "protective" of the child's future and wellbeing, and perhaps an instinct to "take care of" the child client. This reaction is frequently highlighted in the literature about countertransference with children. Recalling the literature review of Chapter II, Annie Roger's relationship with her child client Ben beautifully highlights the sometimes painful, yet almost inevitable, arrival at maternal or protective countertransference with child clients. The closeness of Rogers and Ben speak to a closeness and care that most clearly relates to the relationship between a mother and her child. Also described in Chapter II, several theorists (Esman, 1987; Malawista, 2004; Benstein & Glenn, 1978) comment on the prevalence of the "rescue fantasy" that often occurs in the minds of clinicians who work with children. These theorists note that the child-therapist relationship often takes on characteristics of mother-child as the therapists

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grows to want to keep the child away from pain and harm. Some of these theorists comment that this fantasy to rescue the child from pain often takes the form of wanting to become the child's new, good parent.

Denial of Love

Something that is fascinating about these findings is that while participants did comment on motherly or protective feelings, they did not comment on any feelings of love. It is difficult to imagine motherly sentiments or desires to protect being motivated by anything other than love or, at the least, deep care. If Benstein and Glenn's assertion that therapists choose to work with children in order to fulfill their unconscious wishes to have their own children is true, or if the assertion of Esman and Malawista – that child therapists commonly wish to become the parents of their clients – is true, then it is difficult to imagine that these therapists do not love their child clients. I wonder if the reason participants largely did not comment that feelings of love motivated their motherly/protective countertransference is because it feels "unethical," painful, or difficult to admit to feelings of love.

The literature related to hate and love in the countertransference might shed some light on why participants were so careful to not disclose feelings of love (both in the survey – and in their response to their clients). In the review of literature, Baur's understanding of love and hate in the countertransference is highlighted. Baur comments that it is often much easier for clinicians to admit to feelings of hate than love for a multitude of reasons. As an example, Baur describes his experiences at a conference about countertransference, in which admission of a clinician's hate towards their client was met with interest and discussion, while a clinician's admission of "love" (much less

common) was met with a lack of interest and an increase of discomfort or suspicion. A similar process is notable in the findings – that it was far more common for participants to admit to negative countertransference or no countertransference at all than it was for clinicians to admit to positive countertransference. Baur notes that clinicians often have a fear of moving into unethical or "risky" territory, and that they may more readily admit to hate instead of love in hopes to ensure an ethical boundary. As I stated in the literature review, by not wanting our love for our clients to cause others to suspect our motives or interests, we gladly withdraw our love, or at least, admissions of love, in service of reducing our own discomfort.

All in all, it is undoubtedly beyond likely to me that many of the clinicians who responded to this survey loved their child clients. Of course, some clinicians did admit to this feeling as they responded "I love you too" to their client during the interaction, but the large majority used nuanced language to paint over their love – such as these "maternal feelings," or feelings of deep care and closeness. Without the opportunity to continue interviewing these participants with follow-up questions (such as would be possible in a qualitative, interview based study), we can only speculate about the reasons that clinicians would neglect to admit to love, even when it exists. I imagine that feelings of discomfort around "ethical boundaries" are often at the forefront, but I am left wondering about the origin of these ethical boundaries that many clinicians mention but no clinicians explain. How have so many clinicians come to the conclusion that ethics has something negative to say about loving the client when I cannot imagine this exists (outside from prohibition of sexual relationships) in the ethical guidelines of any mental health discipline.

I sometimes wonder if there is a layer of anxiety based self-concern that underlies the decision to withhold love from a client. Namely, I wonder if we choose to not disclose our love for a fear that we will get hurt – that we will be left, not be loved "back" by our clients, or that we will have to endure one of the most impossible pains – to bear witness to the hurt of a loved one that we cannot alleviate, or that we may be accused of a boundary violation. In a profession that so often places clinicians in dangerous positions to be hurt and devastated, I wonder if we subconsciously avoid the opportunity to overly invest for fear of having our hearts broken in the end. In other words – if we continue to deny our love for our clients, maybe we will not have to admit or come to terms with the pain of a mistake, a failed relationship, or the inability to shield our clients from pain.

A Comment about Clinician Reactions

As explored in the literature review, Ferenczi generally believes that clients often know of our own feelings before we can state them. In the same way that we might often grow to be able to "read" our clients, our clients might grow to "read" us. Whether we would like to admit it or not, if we subconsciously or consciously love our clients, the love exists in the room and affects the relationship and the treatment. As described in the literature review, Karen Maroda tells a story of when she denies her love for a client (she states, "I like you"). Her client becomes sick with narcissistic injury, which is likely motivated by the fact that the client already knew Maroda loved her, and was frustrated her Maroda's withholding. I think it is important to keep this part of the literature in mind when considering the different responses of clinicians. Primarily, if Ferenczi and Maroda's assertion (that the client often knows of our feelings before we state them) is true, then it is largely useless to deny our feelings of love when our clients assert their

own. If we do love our clients and we choose to not admit it, our disingenuous responses are clear to our clients – that we do not believe our clients are worth our love, whether it exists or not, or that fear of negative consequences to ourselves (which would be hard for child clients to imagine) are keeping us from being congruently genuine. For example, PARTICIPANT 5 describes she feels her client thought she was being withholding, and later describes she wishes she had used the word "love" instead of a defensive switch to the word "caring." Given that Carl Rogers many years ago noted that empathy, unconditional positive regard, and congruence/genuineness are the essential ingredients of a healing relationship, omission of the crucial genuineness would seem worrisome.

As noted in the findings, the majority of clinicians had a response that was coded as "dismissive or avoidant." In such situations, the clinician would not acknowledge their own feelings about the situation, or would simply not address the comment at all. I cannot ignore how hurtful these responses feel as I read them. Especially for children who have such trauma histories with interrupted or unhealthy attachments, admissions of love can be difficult and painful, and leaving these experiences unexplored can only exacerbate pain and difficulty. I imagine for many of these clients described, the experiences of having love be returned is rare, I wonder how positive an experience of sharing mutual love with a caring adult could be for many of these children. It saddens me to see that our "ethical boundaries" and perhaps our own insecurities could be denying a child of an experience of mutual love and appreciation.

The Importance of Feeling Effective

I am very shocked by the overwhelming degree to which clinicians believe their response had either a positive effect or no effect on the client or the therapeutic

relationship. I find this very difficult to believe as the responses varied pretty widely, but yet all clinicians seem to believe they made the "right" decision in the situation and report they would not change their reaction if they could have some sort of "do-over."

I think clinicians' inability to admit that their clinical judgment was, perhaps, not the soundest choice, aligns with clinicians' needs to feel effective in difficult situations. I think there are several layers to this issue. Primarily, I think it is likely difficult for all professionals, especially in the human services, to admit they have made an error at the expense of the psychological and social wellbeing of another. In a field that has such a deep sense of noticeable ambiguity (it is often, and rightfully, impossible to predict what the right decision will be), this right to "mistakes" is complicated by the high degree of responsibility we take on for our work. In other words, how do clinicians cope with balancing natural ambiguity and the importance of making sound, and right decisions? I imagine that part of this dilemma involves creating a culture in which admitting to mistakes is minimized. Admitting to mistakes is universally difficult, and admitting mistakes of clinical judgment with psychologically and socially "at-risk" children is even harder – especially when it is not in the context of a trusting, supportive relationship and discussion. If the precept that we cannot change what we do not acknowledge is correct, a lack of openness to the possibility of error is another worrisome aspect of these findings.

Attachment Styles and Trauma

It seems as if the prevalence of attachment disruptions and other types of trauma histories (which was the presenting problem of 72.7% of children being referenced in this study's responses) deserves further discussion. While it is absolutely true that individuals, including children, respond to and cope with traumas (including disruptions in

attachment) in a variety of different ways, I would imagine that most experiences of

trauma (especially relational trauma) deeply affect one's conceptualization of love and

care. I was struck that there was hardly any mention of how the clinician was able or

unable to conceptualize the effect the child's trauma or attachment style had on the

interaction or the child's use of the word love. For a child with deep histories of

attachment disruptions and trauma, the word "love" can be loaded with meaning, and to

admit love for another (in this case the therapist) can also feel risky or guilt inducing.

It is my opinion that leaving these experiences unexplored is an absolute

disservice to the client. It is also my opinion that it is a disservice for us to not be honest

about our feelings with our clients (perhaps – it is important to also note here that honest

responses do not have to include hurtful responses). For a child client who has never been

wholly and healthily loved – a clinician could imagine the healing nature of a loving

therapeutic relationship. For a child client who understands love as painful and full of

violence – a clinician could imagine the healing power of exploring the meaning of love

and experiencing the healing power of deep and caring love. After all, with trauma

treatment, the relationship is almost always at the center of transformation and healing.

As someone without a history of significant attachment disruptions, I still imagine feeling

deep pain if I were to disclose my love for another and have that statement dismissed or

ignored – I cannot imagine what this might feel like for an individual who has a

tumultuous relationship with love in general.

Suggestions for Improving this Study and in Future Research

Improving sample diversity and sample size. In future research, if possible, it

would be beneficial to increase this sample size. Increasing sample size would allow for

the researcher to arrive to more realistic understandings of patterns that arise in the data. In increasing the sample size, the researcher might also be able to make more valid connections between data. For example, while it was noticed that two of the three participants that reported having 1-3 years of experience (on the "greener" end of the participant pool) reported telling their child client "I love you too," there cannot be any remotely clear connections between a clinician's years of experience to a clinician's likelihood they will disclose feelings of love to their client in the current sample. If a larger sample were obtained, it might be more possible to make such clear connections (or not).

It would also be important to increase the diversity of the sample, if possible. Increasing the diversity of the sample would, inherently, increase the generalizability of this study – which is currently quite low because the sample is fairly narrow in a few, poignant elements (i.e., race and gender). It is important to include more persons of color, males, and gender-queer persons into a future survey in order to ensure the findings do not simply convey the opinions and actions of white, female clinicians.

Consider including personal interviews. Further research about this topic might benefit from using qualitative, personal interviews as a method of data collection or a supplement to mixed methods, online survey. As discussed in **Chapter II – Methodology**, there are definite benefits to using anonymous, online surveys in data collection (ensures participant confidentiality to – hopefully – increase the honesty of responses, and ensures an ease of access to participants), there are also a variety of shortfalls. In analyzing my data, I find myself constantly wishing I had the opportunity to ask participants a variety of follow-up questions (such as, "What do you mean by that?"

"Can you tell me more about that?" etc.). Using a confidential, online survey does not allow for this to be a possibility. Some participants commented that it might be helpful to use qualitative interviews to research this topic, and commented on the "awkward" nature of the survey format with this particular topic.

I also wonder if using personal interviews might mitigate the participants' defensiveness about their chosen interventions (described above). I wonder if creating an environment of acceptance and inquiry might allow for more openness and honesty about the clinicians' understandings of how their responses affected their clients or the therapy.

Of course, using more personal interviews would not change the inherent bias in the analysis of data. As described in the introduction, I arrive to this topic with my own biases. It is entirely possible, and also likely, that my biases have affected the way in which I view the data and the ways in which I structured this survey. I arrived to this research study with my own guilt about not disclosing my feelings to child clients in the past, which could have affected the ways in which I expected clients to feel about their interactions.

Address feelings of love more directly. In future studies, it seems important for the researcher to address a clinician's possible feelings of love for a client in a way that is more direct. After completing this survey and reviewing data, I noticed that I did not use the world "love" in the survey questions at all. I am stuck wondering, did the participants love their clients? I wonder if one additional question could be: "Did you have any feelings of love towards this client? If yes, could you describe these feelings? If no, could you comment on why you felt you did not have feelings of love for this client?"

Conclusion

      Given that this study has been the first of its kind, and the first to explore the phenomena at hand, there is a great deal of improvement and considerations to be made moving forward. Along with these possible improvements, however, there is a variety of surprising and interesting data that future research is able to stand on for support. A major strength of the current study, despite its limitations, therefore, is that it was done at all.

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Appendix A

Smith College School for Social Work HSR Approval Letter

SMITH COLLEGE
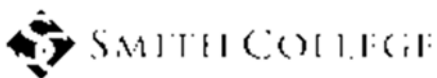
November 17, 2014
Alexandra Shumway

Dear Alexandra,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

Informed Consent

SMITH COLLEGE

Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA
…………………………………………………………………………………
Title of Study: Clinicians' Experiences of Explicitly Stated Love in the Transference with Child

Clients

Investigator(s):

Alexandra Shumway, Social Work Student XXX

 XXX XXXX, ashumway@smith.edu

…………………………………………………………………………….
Introduction
- You are being asked to be in a research study about how clinicians choose to respond when their child client states "I love you" in individual therapy.
- You were selected as a possible participant because you are a therapist holding a master's degree or higher in social work or other clinical discipline, you have an LCSW or LICSW or other legal license to practice mental health treatment, you have conducted or you conduct individual therapy with clients under the age of 12, and you have had a client under the age of 12 state "I love you" to you, the therapist, in session.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
- The purpose of the study is to consider the clinical, ethical, and other implications of a therapist's response to a child client's telling the therapist "I love you."
- This study is being conducted as a research requirement for my master's in social work degree. Ultimately, this research may be published or presented at professional conferences, or in later secondary analyses of these data.

Description of the Study Procedures
If you agree to be in this study, you will be asked to do the following things: spend about a half an hour filling out a survey with questions about yourself, your child client, and the experience you had with this client.
Risks/Discomforts of Being in this Study
The study has the following risks: This survey, although unintentionally, may conjure up difficult memories of the client being discussed or this specific situation. It may also evoke feelings of regret or guilt if you wish you had handled the situation differently, although this is certainly not intentionally implied in the survey. If you are feeling any distress over memories of your client or your experience, I encourage you to speak with your supervisor or seek alternative supervision. If you experience more than a mild discomfort that would permit you to finish this survey, you will be given the opportunity to withdraw and, optionally, to explain your reason to withdraw at any

time. At this point and at the end of the survey you will be provided my contact information if you have any questions or suggestions about this survey or research.

Benefits of Being in the Study
- The benefits of participation are: upon finishing this survey, you will have contributed to larger understanding of this topic for the researcher, those who read this thesis, and those to whom the knowledge is disseminated. Potential benefits also include some time to reflect on an important experience with a client, which could influence your future work in a positive manner.
- The benefits to social work/society are: The field of social work and the general society might also benefit from this study by creating a stronger understanding of therapists' responses to transferential love in children, a topic which is rarely mentioned in literature or discussed amongst therapists or students. This study could also encourage students to more intentionally consider the effects of their actions in response to such expressions, and consider alternative responses and outcomes.

Confidentiality
- Participants in this study will remain anonymous. Although I will ask participants for demographic information in order to better document the diversity of participants in the study sample, I will not be collecting or retaining any amount of personal information that could be identifying.

Payments/gift
- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw
- The decision to participate in this study is entirely up to you. You may refuse to take part in the study by not completing the survey, and you may withdraw from participation in the study at any time while completing the survey without affecting your relationship with the researchers of this study or Smith College. You have the right to not answer any single question. If you choose to withdraw during the survey, I will not be able to access any of your answers or information provided. To withdraw during the survey, you may simply exit the survey. Once you have completed the survey, it will no longer be possible to rescind the data you have supplied or withdraw, as your answers will not be identifiable.

Right to Ask Questions and Report Concerns
- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Alexandra Shumway at ashumway@smith.edu or by telephone at (XXX) XXX-XXXX. If you would like a summary of the study results, one will be available from the Smith College online thesis collection once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent
- By pressing the "I understand and would like to continue in this survey" button below, you have indicated that you fit the criteria for participation and have decided to volunteer as a research participant for this study, and that you have read and understood the information

provided above. If you have decided not to participate in this study, please choose the "Exit" button below.

....

Sample Recruitment Email

Dear *[NASW _____ Chapter] [or Listserv][or Clinician],*

My name is Alexandra Shumway and I am an MSW student at Smith College School for Social Work. I am currently conducting an empirical study for the completion of my master's thesis. The purpose of this study is to address how clinicians choose to respond when child clients explicitly inform a therapist of their transferential love. In my research and personal experience, there is a large gap in psychodynamic literature and conversation that could be filled with answers or suggestions to therapists in the midst of such a situation – which can be an emotional, uncomfortable and shaming "ethical minefield." Most specifically, this research study aims to answer the question: What are the theoretical, practical and emotional aspects of clinicians' responses to such explicitly stated transferential feelings of love from a child client? What are the implications of these responses for the client, the interventions, the alliance, and the therapists' own hearts and minds?

This survey will be available for clinicians who hold a master's degree (or above) in social work, psychology, or a related therapeutic discipline; who have a license to practice such as the LCSW or LICSW, or equivalent license in a related discipline; who practice or have practiced individual therapy with children under 12 years old; and who have had the experience of a child client stating "I love you" in session. Participants may be of age and years of experience post-licensure, of any theoretical orientation, and of any gender, religion, sexual orientation, ability, race, etc.

I certainly hope to have as many participants in this survey and study as I can find, and I am hoping for your help in doing so! I ask that you please consider posting the link to the survey (below) on any relevant website you think might capture attention of eligible participants, passing along the link to any possibly eligible participants through a relevant listserv, or sending the link to any clinician in particular you imagine might be eligible. If you are able to post the link to a website, or to send it out on a listserv, I would greatly appreciate hearing back from you so that I might know the circles in which the survey exists.

I greatly appreciate any help and attention to this study. Please find the link below:

[Insert Link Here]

Thank you!

Alexandra Shumway, Social Work Student

Survey

I. Thank you for your interest in completing this survey for this study regarding clinicians' experiences responding to child clients when the clients state "I love you" in session. You are eligible to participate in this study if you: 1) Hold a master's degree or higher in social work or another clinical discipline, along with a license to practice such as an LCSW or LICSW, 2) conduct or have conducted individual therapy with child clients (under the age of 12), 3) have had a client under the age of 12 state "I love you" to you, the therapist, in session. If all of these criteria apply to you and you would like to continue with the survey, please press "continue." If these criteria do not apply to you, I thank you for your interest, but ask you to please press "exit" to leave the survey.

II. Informed Consent – Please see Appendix B. As described in the consent, this section will have the directions to press either: "I understand and would like to continue this survey," or "exit."

III. Thank you! You will now be asked to complete a few questions about your child client, and the experience you shared when your client told you "I love you" in session. Please remember that this survey is anonymous and you can exit the survey at any point.

IV. How many child clients have told you they love you?
        Choices:
        ____ 1
         ____ 2-4
         ____ 5 – 10
        ____ More than 10

If this has happened to you more than once, please think of one situation with one client in particular. You will have the chance to describe more experiences with other clients if you choose to do so.

V. What was the setting in which you worked with this client?
            ____ Private Practice
            ____ School
            ____ Part of a Public Agency
            ____ Other, Please describe: _____

VI. Without disclosing any potentially identifying information (names, location, etc), please describe the client you are thinking of in a few sentences.

VII. Please describe any countertransference responses you were aware of towards this client.

VIII. Did you use any supports to discuss your countertransference? Please choose all that apply.

_____ No supports
_____ Direct supervisor
_____ Secondary supervision
_____ Peer supervision
_____ Other (please specify _____)

IX. Please describe your relationship with the primary caregivers of this client.

X. Please describe the situation in which your client said "I love you."

XI. Please describe your level of anxiety (if any) about producing an answer for your client.

_____ No anxiety at all
_____ Little anxiety
_____ Medium anxiety
_____ A lot of anxiety
_____ Severe anxiety

XII. What was your response to your client when the client said "I love you"? Please try quote your verbal responses, if any, or describe your nonverbal responses as clearly as you can remember them.

XIII. What was your client's response to your answer?

XIV. Do you think your response influenced your relationship or the treatment in any way? If so, how?

XV. Looking back, is there anything you might have done differently in this situation?

XVI. Did you use any supports to manage your feelings about this situation? Please choose all that apply.

_____ No supports
_____ Direct supervisor
_____ Secondary supervision
_____ Peer supervision
_____ Other (please specify_____)

XVII. Would you like to describe an additional situation with a different client? Please choose yes or no.
- If participants choose "Yes", they will revisit questions V through XVI again. They can do this as many times as they wish. If participants choose "No," they will continue to XVIII.

XVIII. What advice might you give to a young clinician working with a child client as to how best to manage a situation wherein the child told this young therapist "I love you"?

XIX. Is there any other information you would like to offer about this topic?

XX. The next few questions pertain to your (the therapist's) demographic information. I ask you to provide these data so that I may accurately describe the diversity of this study's participants.

XXI. How many years have you conducted or have been conducting individual therapy with children?
    ____ Less than 1 year
    ____ 1 – 3 years
    ____ 3 – 5 years
    ____ 5 – 8 years
    ____ 8 – 10 years
    ____ More than 10 years

XXII. What races or ethnicities do you identify with? Please check all that apply.
    ____ Central African
    ____ East African
    ____ West African
    ____ Southern African
    ____ African American/ Black
    ____ American Indian or Alaskan Native
    ____ Pacific Islander
    ____ Caribbean
    ____ European American/White
    ____ Northern European
    ____ Southern European
    ____ Mexican, Mexican American, Chicano
    ____ Latino/Latina
    ____ Middle Eastern or North African
    ____ South Asian
    ____ Southeast Asian
    ____ East Asian
    ____ Biracial, multiracial, mixed race
    ____ Other (Optional to describe: _____)

XXIII. What is/are your gender identity/identities? Check all that apply.
    ___ Male
    ___ Female
    ___ Transgender
    ___ Genderqueer, Genderfluid, Gender non-conforming
    ___ I do not identify with a gender
    ___ Other (Optional to describe: _____)

XXIV. What is your theoretical orientation? Check all that apply.
          ____ Psychodynamic (Ego Psychology, Self Psychology, Object Relations…)
          ____ Psychoanalytic
          ____ CBT
          ____ DBT
          ____ Behavioral
          ____ Intersubjecive, Relational
          ____ Other (Please describe _____)

XXV. Do you have children of your own?
          ____ Yes
          ____ No

XXVI. Do you have suggestions for the improving this research study?

XXVII. Thank you for your participation! If you have any questions, or would like to directly share any thoughts about research, please contact me using the phone number or email provided below.

If the participant chooses to exit at any time (there is a "quit this survey" button on every page), they will be brought to the following page:

You have chosen to withdraw from this survey. Thank you for your time! Please understand that none of your answers will be used for data collection in this study. If this is a mistake and you would like to continue, please restart the survey.

Website

Found at: https://www.surveymonkey.com/r/clientiloveyousurvey

Thank you for your interest!

Thank you for your interest in completing this survey for this study regarding clinicians' experiences responding to child clients when the clients state "I love you" in session. You are eligible to participate in this study if you:

1) Hold a master's degree or higher in social work or another clinical discipline, along with a license to practice such as an LCSW or LICSW.
2) Conduct or have conducted individual therapy with child clients (under the age of 12)
3) Have had a client under the age of 12 state "I love you" to you, the therapist, in session.

If all of these criteria apply to you and you would like to continue with the survey, please press "next." If these criteria do not apply to you, I thank you for your interest, but ask you to please exit the survey.

Next

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Check out our sample surveys and create your own now!