

Countertransference and the Boundary of Self

The Use of Self in the Therapeutic Alliance

Thomas M. Baier, MHS, LPC, CADC, CCS

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To be a proficient counselor...

***It is not sufficient to be merely
a good person with good
intentions.***

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The Counselor's Values

●Recognize that you are not value-neutral

●Be aware of *value imposition*

- How your values influence your interventions
- How your values may influence your client's experiences in therapy

The Counselor's Values

- Your job is to assist clients in finding answers that are most congruent with their own values
- Find ways to manage value conflicts between you and your clients
- Begin therapy by exploring the client's goals

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The Counselor's Values

- Become aware of your biases and values
- Become aware of your own cultural norms and expectations
- Attempt to understand the world from your client's vantage point
- Gain a knowledge of the dynamics of oppression, racism, discrimination, and stereotyping

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The Counselor's Values

- Study the historical background, traditions, and values of your client
- Be open to learning from your client
- Challenge yourself to expand your vantage point to explore your client's ways of life that are different from your own
- Develop an awareness of acculturation strategies

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Self

All Counselors should know what triggers them, and what are their areas of vulnerability and conflict



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Self

When counselors act out, or start to burn out, it's largely due to the issues that get stirred up inside of them, causing more symptoms than insight.

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Self

Counselors are the toxic waste dump of their clients. It is very stressful, and counselors, like anyone else, use denial and rationalization when they are needy and regressed.



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Self-Awareness

Without a high level of self-awareness, the counselor will hinder the progress of their clients as the focus of therapy shifts from meeting the client's needs to meeting the needs of the therapist.

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Counselors must be aware of their:

- . Needs**
 - Areas of “unfinished business”
 - Personal conflicts
 - Defenses
 - Vulnerabilities

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Ask yourself these:

- What are my motivations for becoming a counselor?
- What are my rewards for counseling others?

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Interfering Motivations

- ◆ Working primarily to be appreciated by others, instead of what's in the best interest of the client
- ◆ A tendency to give advice and to direct another persons life, can lead to excessive dependence on the counselor
- ◆ Working to gain the acceptance, admiration, and awe of clients.

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Unresolved Personal Conflicts

Counselors should be aware of their:

- Biases
- Areas of denial
- Unresolved issues

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Personal Therapy During Training

● It helps to know what the experience of being a client is like.

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Issues that may Surface for Clinicians

A need to:

- tell people what to do
- have all the answers and be perfect
- be recognized and appreciated

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More issues

- A fear of doing harm
- To deny or not recognize client issues that may relate to their own.
- A desire to take all pain away from clients.

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Lifelong Learning

- Committed professionals engage in lifelong self examination, as a means of remaining self-aware and genuine.

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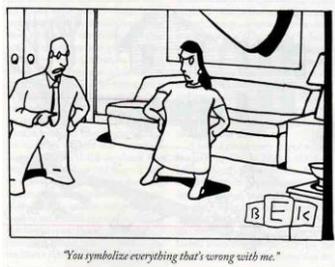
Countertransference

Knows no boundaries in terms of:

- Race
- Gender
- Ethnicity, etc

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“You symbolize everything that’s wrong with me”.



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Countertransference

●In 1910, Freud said:

“ We have become aware of the countertransference, which arises in the therapist as a result of the patient’s influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize it, this countertransference in himself and overcome it...”



Countertransference

- “...no counselor goes further than his own complexes and internal resistances will permit”

- “...we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his observations on his patients” (Freud)

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Countertransference

- “ Anyone who fails to produce results in a self-analysis of this kind may at once give up the idea of being able to treat patients by analysis” (Freud)

- Countertransferences may lead to blind spots in the work with the patient

- Thus he recommended “continuous self analysis” → “training analysis” → “analysis every five years” → plus “constant self-analysis”

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Countertransference

● *Totalistic definition*: any therapist reaction to a client, whether unconscious or conscious, in response to transference or other factors; not necessarily detrimental to therapy; potentially useful if understood (e.g., can provide insight into client or treatment)

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Countertransference

- Totalistic definition does not distinguish source of therapist reaction (e.g., reality, inexperience, fatigue, therapist's unresolved issues)
- Different implications for what to do based on origin of reaction (e.g., supervision, rest, therapy)
- Totalistic definition of limited utility

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Countertransference

- *Interpersonal theory* distinguishes between therapist reactions likely to be common across therapists (reality based "objective countertransference") from reactions likely to be idiosyncratic or unique to a therapist ("subjective countertransference")

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Countertransference

Integrative definition, on which most research is based, is similar to subjective countertransference -

- Therapist reactions to a client stemming from areas of unresolved conflict in the therapist's personal history
- The therapist's transference to the client
- Less narrow than classical definition
- Retains emphasis on source of countertransference.

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A Structural Model of Countertransference

- Origins
- Triggers
- Manifestations
- Effects
- Management

A Structural Model of Countertransference

- Origins: therapist areas of unresolved conflict that give rise to countertransference
- How to measure?
 1. Self-report: relies on therapist's ability and willingness to respond accurately (e.g., to measures, interview questions)
 2. Discrepancies between self-report and peer report: "blind spots" (e.g., Cutler, 1958; Rosenberger & Hayes, 2002)
 3. Projective tests: Core Conflictual Relationship Theme (needs, wishes, responses from others)
 4. Reaction times to potentially conflict-relevant words

A Structural Model of Countertransference

- Triggers: factors that evoke or stimulate therapist's unresolved conflicts, such as client appearance, what client says or does, changes in structure of therapy
Origins + Triggers = Causes
- How to measure?
 1. Audiotapes or videotapes of client actors (laboratory research)
 2. Themes in what client talks about (field research)
 3. Client non-verbal behavior (Penman, SASB)

A Structural Model of Countertransference

● **Manifestations:** therapist reactions when unresolved issues are provoked

How to measure?

1. Behavioral: avoidance; over-involvement; Inventory of Countertransference Behavior (trained raters, supervisors)
2. Cognitive: inaccurate recall of client material
3. Emotional: anxiety; Therapist Appraisal Questionnaire (self-report)
4. Visceral: anxiety (galvanic skin response)

A Structural Model of Countertransference

● **Effects:** consequences of manifestations on the quality of therapy process and outcome

How to measure?

1. Depends upon hypotheses
2. Countertransference has been linked to working alliance, session depth, session smoothness, client satisfaction with therapy.

A Structural Model of Countertransference

● **Management:** therapist strategies for coping with countertransference manifestations

How to measure?

1. Supervisor ratings of extent to which trainee possesses factors that enhance countertransference management
2. Self-reported in-session coping mechanisms (Management Strategies List)

Empathy

**To be empathic
vs.
To demonstrate
clinical empathy**

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Countertransference

Countertransference is also:

- An appropriate and normal response to the patient
- A very useful tool of treatment
- Can be used to understand the patient communications, feelings etc

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Patterns of Transference & Countertransference

NEEDY PATTERN

Transference

- Sees therapist as nurturing mother; dependent
- Sees therapist as non-nurturing mother; hurt, angry

Countertransference

- Overly involved in caring for client
- Repulsed by client's needs

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Patterns of Transference & Countertransference

NEED-DENYING PATTERN

Transference

- Denies need for nurturing or help from therapist

Countertransference

- Happy that client doesn't need anything

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Patterns of Transference & Countertransference

INSECURE PATTERN

Transference

- Afraid therapist is judgmental of her or doesn't like her

Countertransference

- Overly involved in reassuring client
- Repulsed by client's insecurities

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Patterns of Transference & Countertransference

ISOLATED PATTERN

Transference

- Avoidance of personal/emotional relationship with therapist or denial of it

Countertransference

- Treating relationship as if it were only instrumental
- Moving too quickly to connect with the client

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Patterns of Transference & Countertransference

COMPLIANT PATTERN

Transference

- Pretends that everything the therapist does works.

Countertransference

- Believes the client's compliance.

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Patterns of Transference & Countertransference

DEFIANT PATTERN

Transference

- Refuses to cooperate with much of the therapy. Fights with therapist and criticizes her approach.

Countertransference

- Feels ineffective and incompetent. Feels hurt by criticisms.
- Becomes frustrated with client. Gets into arguments and power struggles with client.

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Patterns of Transference & Countertransference

PASSIVE-AGGRESSIVE PATTERN

Transference

●Experiences the therapist as pressuring her to perform. Consciously wants to please the therapist, but fails to do therapy correctly, or if she does, fails to progress in life or denies progress. Unconsciously, this is an expression of anger at the therapist and an attempt to defeat the therapist, who she experiences as attempting to control her and change her.

Countertransference

- Becomes frustrated with the client for failing.
- Feels ineffective and incompetent.

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Patterns of Transference & Countertransference

CONTROLLING PATTERN

Transference

●Refuses to allow therapist to do much. Must be in control of the therapy.

Countertransference

●Gets into a power struggle with the client.

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Patterns of Transference & Countertransference

VICTIM PATTERN

Transference

●Complains to therapist about his misery in unconscious attempt to get therapist to do it for him.

●Blames therapist for his problems for same unconscious reason.

Countertransference

●Fails to see victim stance and keeps trying to reassure and encourage client.

●Becomes angry and frustrated at client.

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Patterns of Transference & Countertransference

CODEPENDENT PATTERN

Transference

- Tries to take care of therapist. Picks up on clues of therapist's pain or life struggles and engages therapist in talking about them. Notices therapist's insecurities and assuages them.

Countertransference

- Allows client to take care of him.

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Patterns of Transference & Countertransference

SUSPICIOUS PATTERN

Transference

- Suspects that the therapist harbors negative feelings toward him that are hidden or that the therapist will at some point turn on him or abandon him. Doesn't trust positive things he sees.

Countertransference

- Becomes annoyed at client for lack of trust and hides this from client, thereby making client's fears come true.
- Pressures client to trust prematurely.

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Patterns of Transference & Countertransference

AGGRESSIVE PATTERN

Transference

- Periodically becomes enraged at therapist over a certain behavior of situation that develops.
- Criticizes the therapist's handling of the therapy.

Countertransference

- Becomes frightened of client's anger and tries to avoid triggering it, leading to non-therapeutic behavior.
- Becomes angry at client and shows it directly or covertly.
- Feels hurt by criticism, leading to feelings of incompetence.
- Argues with client about content of criticisms.

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Patterns of Transference & Countertransference

SELF-JUDGING PATTERN

Transference

- Constantly blames himself for poor performance in therapy and life. Often expects the therapist to feel the same way.

Countertransference

- Tries to reassure client without directly working on the inner critic.
- Becomes annoyed with client for constant self-judgment, thereby contributing to it.

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Patterns of Transference & Countertransference

CHARMING PATTERN

Transference

- Entertains the therapist with fascinating stories. Engages the therapist's sexual interest. Charms the therapist.

Countertransference

- Becomes more interested in the client's charm (in whichever form) than in engaging in therapy.

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Patterns of Transference & Countertransference

BRITTLE FORM OF DEFENSIVE PATTERN

Transference

- Becomes deeply hurt by challenges from the therapist (or things perceived that way) and reacts with brittle defenses.

Countertransference

- Tries to reassure the client without dealing with underlying issues.
- Keeps going with the challenge.
- Becomes frustrated that client can't deal with any challenges.

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Patterns of Transference & Countertransference

PRIDEFUL PATTERN

Transference

- Expects therapist to appreciate or admire him.
- Acts superior and demeaning toward therapist.

Countertransference

- Therapist admires client or gives appreciation, thinking client needs support.
- Therapist becomes angry at client for grandiosity or condescension and challenges him in an unsupportive way.

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Patterns of Transference & Countertransference

ENTITLED PATTERN

Transference

- Client expects special favors from therapist around money, time, etc.
- Client expects therapist to give him exactly what he wants.
- In making these demands, the client completely disregard any needs or limits the therapist might have.

Countertransference

- Therapist gives in to client's demands.
- Therapist becomes angry at client's demands and at therapist's needs being ignored.

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More Dangers for the Counselor



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The Issue of Vicarious Trauma



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Vicarious Trauma

- Vicarious traumatization (VT)
- Secondary post traumatic stress reaction
- Secondary traumatic stress
- Secondary traumatic stress disorder
- Compassion fatigue
- Compassion stress
- Soul sadness
- Empathic strain
- Contact victimization

It's not a matter of "If" it's a matter of "When"

Vicarious Trauma

"There is a soul weariness that comes with caring. From daily doing business with the handiwork of fear. Sometimes it lives at the edges of one's life, brushing against hope and barely making its presence known. At other times, it comes crashing in, overtaking one with its vivid images of another's terror with its profound demands for attention, nightmares, strange fears, and generalized hopelessness."

B. Hudnall Stamm, Ph.D.

Definitions

- ☐ Burnout:
 - Related to feeling of being overloaded
 - Work stress
 - Joy of work is lost
 - Can occur in any professional setting
 - Progresses gradually as a result of emotional exhaustion, cynicism, and feelings of inefficacy.
 - Does NOT lead to changes in trust, feelings of control, issues of intimacy, safety concerns, and intrusive traumatic imagery that are foundational to Vicarious Trauma.

Vicarious Trauma

● Vicarious trauma is the process of change that happens because you care about other people who have been hurt, and feel committed or responsible to help them. Over time this process can lead to changes in your psychological, physical and spiritual well-being. (Headington Institute)

Vicarious Trauma

- Cumulative –happens over time as you work with survivors of trauma, disasters, people who are struggling.
- Process of change is ongoing – this is hopeful as it provides opportunities for us to recognize the impact the work has on your lives early and to develop strategies to protect and care for ourselves.

Vicarious Trauma

Empathy

When you identify with the pain of people who have endured terrible things, you bring their grief, fear, anger, and despair into your own awareness and experience.

- What sort of problems or people do you find it easy (or difficult) to empathize with?
- What are some ways that caring about people who have been hurt affects you?

Vicarious Trauma

Feeling committed or responsible to help

Your commitment and sense of responsibility can lead to high expectations and eventually contribute to your feeling burdened, overwhelmed, and hopeless/helpless.

- Can lead you to extend yourself beyond what is reasonable for your own well-being or the best long-term interests of your patients.
- How does your sense of commitment and responsibility to your work help you? How might it be hurting you?

Joining vs. Merging

The empathic process:

- Merging touches our own unresolved issues – our countertransference
- Joining supports differentiation between you and patient– being attuned/in resonance/healthy boundary
- Patients whose boundaries have been so abused/ruptured – it may be nearly impossible for them to maintain appropriate boundaries. It is essential that we have or develop healthy boundaries as clinicians.
- Patients with borderline characteristics will merge easily and violate boundaries frequently and ask us to violate our boundaries

Joining vs. Merging

Warning signs of merging:

- Something will happen in our system to decrease our contact with our felt sense
- We are uncomfortable with someone who dissociates or leaves their body
- We're not ok until they are ok
- We feel unsettled, unclear, tired, not present
- Think about patient outside of session more often than our comfort level
- We think we are indispensable – were are the only ones who can help
- Boundaries get blurred – we go overtime, stay late, we start taking on their stuff, have dreams about them

Joining vs. Merging

Joining

- We need to be grounded and in our bodies and resourced ourselves
- Can't prevent merging but reset boundaries after this happens
- Ask how does merging touch our own stuff? What shadow piece of me is showing up?
- Don't get too caught up in their story
- Stay present within your boundaries without withdrawing – helps patient begin to develop trust
- Come back to your belief in the patients own ability to heal. And the knowledge that they have taken care of themselves for years without us and will continue to do so
- Respect their need for boundaries – on both sides of the relationship

Vicarious Trauma

●Changes in spirituality

- Your deepest sense of meaning and purpose, hope, faith
- Humanitarian workers often refer to this as "existential angst" - being constantly pushed out of your comfort zone and forced to question the meaning of events, and their own and others actions and reactions.
 - What are some ways your work has had a positive influence on the way you see the world, yourself, belief in God, what matters to you? In what ways has the influence been negative?

Vicarious Trauma

Understanding risk factors:

- Personality and coping style
- Personal trauma history
- Current life circumstances
- Social support
- Spiritual resources
- Work style – work/life boundaries
- Professional role/work setting/degree of exposure
- Agency support
- Affected populations response or reaction
- Cultural styles of expressing distress and extending and receiving assistance

Signs and symptoms

- Feeling frustration or anger about a patient's choices
- Thinking about a patient outside of work more than you want to
- Feeling anxious about working with a patient
- Feeling dread when you anticipate seeing a patient
- Feeling more worried than you think is necessary about a patient
- Feeling angry at a patient
- Feeling de-skilled or incompetent when you meet with a patient
- Taking on too much responsibility- difficulty leaving work at end of day – stepping in to control other's lives

Signs and symptoms

- Feeling disconnected or dissociated from the patient, their emotions or the content of the session
- Having physical discomfort or pain while meeting with a patient, which seems connected with what you're working on
- Having other physical reactions to a patient's stories, e.g. increased heart rate, rapid or shallow breathing, nausea, feeling frozen etc.
- Feeling traumatized after talking with a patient about specifics of their abuse
- Wanting to cry during/after meeting with a patient
- Feeling helpless about your work with a patient
- Feeling enraged at a patient's perpetrators

The Key To Survival



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Self Care

- What helps?
- An effective action plan for addressing vicarious trauma and self care will reflect your own needs, experiences, interests, resources, culture, and values.
 - Escape – get away from work/trauma material
 - Rest – do things you find relaxing
 - Play – physical activity, creativity, laugh

Self Care

- Tools of transforming helplessness
 - Awareness** – Being attuned to own needs, limits, emotions, reactions, resources. Mindfulness and acceptance. Keep mind and body in same place.
 - Balance** – Professional and personal – rest/work/play. i.e. Eat lunch/go home at end of shift. Spend time laughing with friends
 - Connection** – To oneself, others, something larger. Decreases isolation, increases validation and hope. An essential part of spiritual connection is to find one's own path to connecting with a sense of awe, joy, purpose, meaning, and hope and visiting it frequently.

Self Care strategies to consider

- Yoga/ Tai Chi /Dance
 - Mindful eating
 - Journaling, singing
 - Travel
 - Personal psychotherapy
 - Eat and sleep
 - Seek spiritual renewal/pray
 - Hobbies, sports, creative interests
 - Bubble baths/movie night
 - Walking/petting dog
 - Establish boundaries separating work from home
 - Guard against addictive behaviors
 - Acupressure/tapping
 - Seek out experiences which instill hope and comfort
- Long baths/aromatherapy
 - Biking, hiking, running
 - Massage
 - Time with friends
 - Sex
 - Laugh
 - Meditation
 - Gardening/baking
 - Forgive yourself

Self Care

- Talk with co-workers about self care strategies that work – share ideas
- Take 2-3 minutes to be still in between appointments
- Develop containment strategies
- Prioritize your own well-being over your patients

Self Care

- Why do you do this work?
- How do you measure success in your work?
- What can you control in your work?
- What are the costs and rewards of this work and how are you personally changing?

The End

**Thanks for being here and
for doing the important
work that you do every
day!**

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