

TRANSFERENCE AND COUNTERTRANSFERENCE AND THE TRAUMA TRIANGLE: ETHICS

3 HOURS

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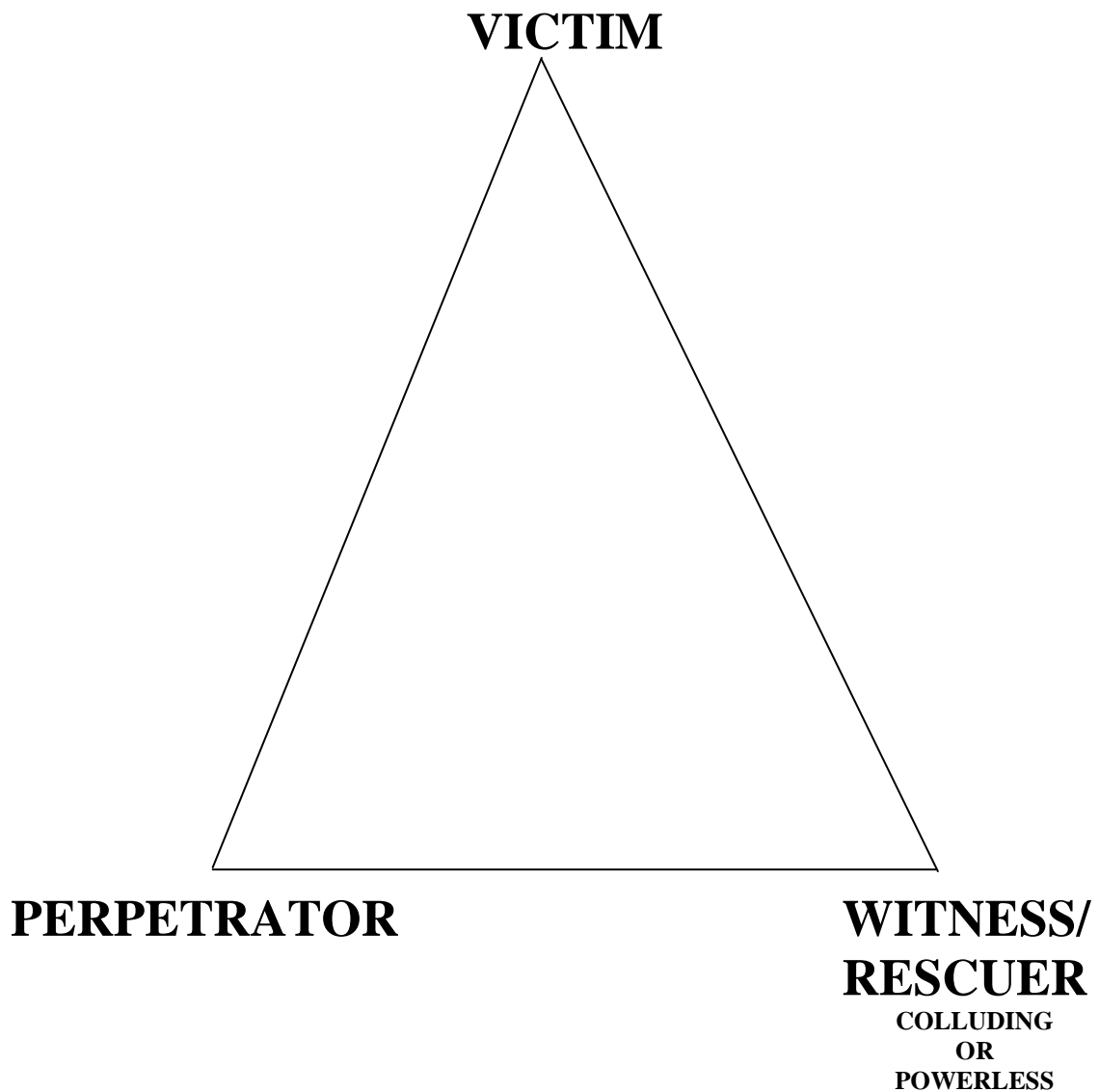
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SUPERVISOR/TEXAS SOCIAL WORK LICENSURE CONSULTATION: INDIVIDUAL AND GROUP “*EASIER SAID THAN DONE*”

Boundaries are the limits that allow for a safe connection based on the client's needs. The law and our professional Codes of Ethics by themselves cannot address most of the situations encountered by therapists and their clients in the difficult work of psychotherapy with traumatized people. The law and code are both narrative and literal and the *real* territory of ethics is ruled by more implicit boundaries, which prohibit actions that betray the client and the therapist. This uncharted territory is the dangerous ground of the therapy relationship, and in which we must steady our course to make rational, relational decisions to protect the client, the relationship and ourselves.



THE TRAUMA TRIANGLE





TRAUMATIC EXPERIENCES

Psychological trauma can be anything that is too much for the person to manage emotionally. There are a variety of life events that are traumatic to a person, including some experiences that for one person may be overwhelming and not overwhelming to another. For Example:

- **SEXUAL ABUSE**
- **PHYSICAL ABUSE/BATTERING**
- **RAPE**
- **FEMALE GENITAL MUTILATION**
- **NEGLECT**
- **EXPERIENCE OF BEING OVER-CONTROLLED OR MONITORED**
- **EXPERIENCE OF BEING CRITICIZED OR BLAMED**
- **WITNESS TO ABUSE OF ANY KIND TO ANOTHER**
- **TORTURE/IMPRISONMENT**
- **POVERTY/HUNGER**
- **WAR/COMBAT TRAUMA**
- **EARLY LOSS OF A PARENT**
- **LOSS OF A CHILD OR SIBLING**
- **DISABILITY/ CHRONIC ILLNESS IN A PARENT / SIBLING**
- **CHRONIC ILLNESS, REPEATED HOSPITALIZATIONS, TERMINAL ILLNESS**
- **ACCIDENTS: AUTO, FIRE, MANUFACTURING, ETC.**
- **NATURAL DISASTERS**
- **POLITICAL TERRORISM**
- **MUTIPLE MOVES DURING CHILDHOOD**



THE FUNCTION OF BOUNDARIES

BOUNDARIES ARE THE LIMITS THAT ALLOW FOR A SAFE CONNECTION BASED ON THE CLIENTS NEEDS. They protect the space between professional and client by controlling the power differential in the relationship.

BOUNDARIES CREATE THE UMBRELLA FOR:

- **SELF DETERMINATION**
- **PRIVACY IN THE RELATIONSHIP**
- **CONFIDENTIALITY**
- **PROFESSIONAL USE OF SELF DISCLOSURE**

“When these limits are altered, the relationship becomes ambiguous, confusing and undefined. Such ambiguity is often experienced as an intrusion into the sphere of safety. The pain from a violation is frequently delayed, and the violation itself may not be recognized or felt until harmful consequences emerge”. (Peterson, 1992



5 STRATEGIES TO MAINTAIN FRAME AND BOUNDARIES

(Pearlman and Saakvitne, 1995)

- 1. DEVELOP A CLEAR THEORETICAL FRAMEWORK FOR THE RELATIONSHIP: (especially with sexual abuse survivors. Grounding in theory helps one notice variations in practice.**
- 2. ESTABLISH A CLEAR FRAMEWORK AROUND THE THERAPY RELATIONSHIP WITH THE CLIENT.**
- 3. KNOW YOURSELF AND WHAT YOU BRING TO THE WORK: STRENGTHS, WEAKNESSES AND VULNERABILITIES THROUGH PERSONAL THERAPY AND PERSONAL SELF REFLECTION. Your story can get entangled with the client's, and influence the frame and your vision of it.**
- 4. GET CASE CONSULTATION AND SUPERVISION FROM AN EXPERIENCED TRAUMA THERAPIST ON A REGULAR BASIS.**
- 5. DISCUSS FRAME ISSUES WITH THE CLIENTS OPENLY OVER THE COURSE OF THE THERAPY, ESPECIALLY AT THEIR INITIATION. For people who have been exploited or humiliated, openly acknowledging, negotiating, and explaining a rationale for boundaries etc in an important relationship is both**



WHY IT HAPPENS: YOU AND THE CLIENT REENACT THE ORIGINAL STORY

THE THERAPIST and the CLIENT are vulnerable to reenact THE THERAPIST'S STORY and THE CLIENT'S STORY

- **DANGER OF A ROLE REVERSAL VIOLATION :**

You might be drawn to have the client care for you if she cared for her mother or if you wanted yours to care for you.

- **DANGER OF A VIOLATION WITH SECRETS:**

You might be drawn to keep a secret *from* the client or *for* the client if there were secrets in your family or in hers.

- **DANGER OF A DOUBLE BIND VIOLATION:**

You might be drawn into feeling trapped or trapping the client in some way if you had a no win situation or she did. (dual relationships cause double binds)

- **DANGER OF INDULGING PROFESSIONAL AUTHORITY**

You might be drawn to take advantage of the client because of the power you have if someone indulged his or her position over you or if it happened to the client.

REENACTMENTS ARE INEVITABLE IN THE TREATMENT OF TRAUMA SURVIVORS. THE DANGER OF BOUNDARY VIOLATIONS ARE ALWAYS PRESENT.

ROSALIE W. HYDE LMSW



ETHICAL TRAUMA TREATMENT IS BASED IN A RATIONALE THAT IS PHASE BASED

PRE-TREATMENT: *SOME* PEOPLE MUST FIRST: Prepare for out-patient therapy.

1. Must be able to tolerate coming to therapy and sitting in the room with some regularity.
2. Work on symptom reduction for the above purpose.
3. Generate self capacities.
4. Avoid direct trauma/ memory work.

STAGE ONE: CREATE SAFETY

1. Building Trust in the relationship.
2. Creating Safety.
3. Learning Basic Self Care/Self Soothing/Grounding/Calming

STAGE TWO: SEPARATE THE PAST FROM THE PRESENT

1. Reconstruction of the Story.
2. Controlled exposure to memory and feelings about the past: Pacing is carefully done. "Make haste slowly".
3. Grieving about what happened.
4. Learn to describe feelings in the "here and now".
5. Understand beliefs about the self and world and change to fit the present

STAGE THREE: A NEW LIFE IN THE PRESENT

1. Learn more about building close relationships outside the therapy.
2. Learn personal boundaries.
3. Finding meaning and purpose.
4. Time for more intense couple's and family therapy
5. Learning about HOPE and FUTURE and IMAGINATION.



SAFER

***S*ELF CARE**—REFRAINING FROM SELF DESTRUCTIVE BEHAVIOR
BY FINDING WAYS OF SELF SOOTHING AND COPING WITH
STRESS

***A*CKNOWLEDGEMENT** OF TRAUMA—ACCEPTING WHAT
HAPPENED AND HOW IT HAS AFFECTED YOUR LIFE RATHER
THAN SEEING YOURSELF AS ‘CRAZY’ OR BAD

***F*UNCTIONING**—TO MAINTAIN NORMAL FUNCTION TO EXTENT
POSSIBLE

***E*XPRESSION**—THE NEED TO FIND A CONSTRUCTIVE OUTLET
FOR FEELINGS: ART, MUSIC, PHYSICAL ACTIVITY, WRITING,
ETC.

***R*ELATIONSHIPS**—MAKING SOCIAL SUPPORTS, INCLUDING A
THERAPEUTIC RELATIONSHIP



COUNTERTRANSFERENCE RESPONSES TO DISSOCIATIVE PROCESSES IN PSYCHOTHERAPY

(Pearlman & Saakvitne)

DISSOCIATION = AN INTRAPSYCHIC DEFENSE AND

AN INTERPERSONAL PROCESS IN THERAPY

Transferences, and real memories and aspects of the self emerge in the relationship and are managed with DISSOCIATION

- **The therapist may parallel the client, unaware of aspects of her client, or herself: she may split off her own ambivalence, or other feelings, or experience unfamiliar inner states that may or may not be hers.**

Dissociative flight from feelings results in not knowing, not being, and not feeling, stimulated by the overwhelming feelings from the shared interpersonal space of the therapy

- **“Splitting” involves dissociation of conflicting feelings when tolerating ambivalence is too much**
- **Clients may dissociate in response to perceived or real interpersonal conflict with the therapist**

Dissociation may protect the person’s frame of reference and world /self view

- **Dissociation serves to preserve values, trustworthiness and love from and for other people and can protect the person’s interpersonal relationships**
- **The person may dissociate to maintain an idealized transference**
- **The illusion of the absence of conflict and ideal may be helpful in the early stage of trust building**

Dissociation may serve to contain Traumatic memories

- **Therapist countertransference interest and zeal can override these safety precautions and push the person into too much too fast**
- **Dissociation is an adaptation to be understood, not a symptom to be purged**

TRAUMA MODELS OF RELATIONSHIP CONTAIN:

- ISOLATION: If one has been hurt one tends to stay away.
- YEARNING: Isolation paradoxically keeps us yearning for closeness, the ever dangerous, yet longed for human need.
- FEARFULNESS: Yearning throws one into fear of: hurt, exploitation, domination, and intrusion, being engulfed, humiliated and degraded.
- DEPENDENCY: When trust, intimacy and nurture are found, they create a terror of abandonment and loss. One can feel resentful of feeling dependent on the care of another.
- VULNERABILITY TO HARM: Dependency on comforting relationships contributes to a vulnerability to repetition of the past trauma, or perceived repetition. It is a failure of self protection and through numbing the adult is predisposed to allow mistreatment. Learned helplessness allows reenactment.
- EXTREME NEEDS FOR CONTROL: Helplessness in the past is responded to by need to control the present. Cooperation, negotiation, compliance feel dangerous. Controlling and dominating others may be the only one feels safe.
- INTERNALIZATION OF AGGRESSIVE MODELS: One who has been abused can be and feel like an abuser. Aggression models aggression.



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COUNTER-TRANSFERENCE AND THERAPEUTIC FRAME

Pearlman and Saakvitne, , 1995

Therapy Frame: includes issues such as

- appointment times, length of sessions, fees, forms of address, shared information, therapist availability, physical space, touch, social manner, language, confidentiality etc
- expectations that boundaries will be identified and interpersonal events noticed and discussed
- initial contact includes this information and sets the stage for the relationship and for predictability and mutual respect

Therapist's Counter-transference responses to the survivor's fear and mistrust can affect the Frame of the Therapy:

- to impose boundaries in response to an identification as an authority figure, or protector
- modify boundaries to dispel the client's perception of her as an abusive authority
- deny or abdicate power rather than provide a healing honest interpersonal experience of respect and negotiation
- alterations or disregard for the established frame will be disruptive and lead to a loss of bearings disrupting faith, trust , identity , meaning, hope, and safety
- maintaining frame provides a context within which the client's disrupted personal frame of reference can begin to be restored

The Client's Transference to the Therapist as a person of Authoritative Power:

- the therapist's power can be perceived as knowledge, control, the power to reject or abandon, the power to hurt or humiliate, or the power to define the truth, as well as to help or heal
- strategies for the client to protect herself from these can be confusing and difficult to the therapist

What to Do?

ASK, EXPLORE before ACTING

Client asks for a change in the frame: hug, extended sessions, therapist disclosure etc.

WE MUST ASK ABOUT!

What would it mean to you? How might it be helpful?

How would it be a problem? Hurt? Does the therapist feel comfortable theoretically or personally with the change?

If a decision is reached to change the frame, the discussion continues over time as to how it is working, how they both are impacted.



CASE CONSULTATION CONSIDERATIONS

Identification

Gender, Age, Country of Origin

Marital or partnership status, previous marriages, age of first marriage, common law

Children, pregnancies, incompleted pregnancies

Specific physical characteristics and/or disabilities

Work and School History

Family Structure:

Family History: Mother/Father Status/length of marriage; how old client when status changed (divorce, death of parent, parent leaving)

Health and Illness: Parents, siblings - age of client; serious illness or incapacity in any family member;

Substance abuse in family

Death: Parents, siblings, incompleted pregnancies (age of client)

WORK ISSUES: Occupation of Mother/Father. Was father/mother ever out of work? How long? Age of client.

Presenting Problem:

How does client identify the problem?

Previous treatment and/or Mental Health conditions: client and family members; when, Where, and how long? Why and How did the treatment end?

Trauma History in client and/or family members:

Therapy Frame and Treatment Issues:

How client referred: your first contact; related to other clients, friend? Boundary issues

Your first impression of client- gut reaction; feelings about intake and relationship to date, feelings this client stirs in you.

Questions and/or concerns that prompts your choice of this client for consultation. Are these concerns relevant to other client concerns that you have- **look for patterns.**



IF YOU FIND YOURSELF DOING ANYTHING OUT OF THE ORDINARY IN THE THERAPY OR DRAWN TO DO SOMETHING UNUSUAL WITH A CLIENT: That is, if it is outside of your frame: time, money, contact between sessions, taking gifts, doing for or having them do for you etc.

STOP
YOU NEED A CONSULTATION!

Benefits to the Therapist of Consultation

- Others to witness, confirm, challenge her own experience.
- Friendly guides through the counter-transference tangle
- Support for difficult work from those who know
- Support for you and each other as you learn new ideas and challenge assumptions about therapy
- You learn more
- It is Fun



WHAT HAPPENS TO THE THERAPIST WHEN A VIOLATION OCCURS

FEELINGS OF SHOCK, SHAME AND FEAR

- Face personal imperfection
- Shame compels seeking relief
- Fear of reprisal and litigation

SELF PROTECTION OR SELF EXAMINATION

- Feel guilty
- Conflict over whether to defend self or repair the damage with client
- Owning up to it may be dangerous, and cause paranoia

SELF PROTECTION OR ACKNOWLEDGMENT AND TAKING OWNERSHIP

- Make a choice
- Reconciliation alleviates the shame
- Gives the client opportunity to repair trust/unlike in the client's history



RELATIONAL MODEL OF CONSULTATION/SUPERVISION

3 Key dimensions to compare paradigms:

1. The nature of the consultant's authority:

The consultant has general knowledge, experience and proficiency to train.

Consultant owns and honors general knowledge he/she recognizes that she has no special access to knowledge or truth about the consultee, the patient, or the dynamic work being consulted about. Our theory purports that the consultant and consultee co-construct, mutually derive, and negotiate meaning about the processes and data of the therapeutic work and the supervision. They share power and authority.

2. The data considered by the consultant to be relevant for the process

Dimension 2 and 3 are closely related: Some consultants focus on the patient's dynamics may engage in a more didactic way, teaching etc. The consultant who focuses on the reactions of the therapist may tend to clarify, confront, and contain anxiety etc about the treatment or in the Countertransference.

3. The consultant's primary mode of participation in the relationship

Rather than be patient centered only, or therapist centered only, the trauma focused relational consultation focuses on multiple levels of the parallel process:

The relational consultant sees both the patient's conscious and unconscious expression of his dynamics and the consultee's conscious and unconscious expression of the experience of the patient, of himself, and of the consultant. This is a relational matrix, including the treatment dyad, and the consultation dyad.

In a Safe and extended Consultation dyad: the relationship between consultant and consultee may enact between them aspects of either or both of their relationships with the organization in which the supervision takes place, as well as what is happening in any given treatment.

EIGHT TRANSFERENCE-COUNTERTRANSFERENCE POSITIONS

Davies and Frawley, 1994

4 COMMON RELATIONSHIP DYADS WITH 8 DIFFERENT RELATIONSHIP POSITIONS IN SURVIVORS OF SEXUAL ABUSE

1. Uninvolved Non abusing Parent ____ The Neglected Child
2. Sadistic Abuser __ The Helpless Impotent Enraged Victim
3. Idealized Omnipotent Rescuer _____ Entitled Child
Demanding Rescue
4. Seducer _____ Seduced

- *These are alternately enacted by the therapist and survivor in the Transference and counter transference in the therapy and are often only identified by the therapist's attention and understanding of the counter transference experience.*
- *treatment is only complete when all combinations and permutations of these relational roles are worked through by enactment and interpretation*

Unseeing Parent ____ Unseen Child

The survivor enacts either side or both sides of the relational pair sequentially, while the therapist projectively identifies with and enacts the complementary role. Often it is the first T/CT to emerge.

- The patient may identify with her parent and act cold, unavailable and rejecting; may accuse the therapist verbally or nonverbally of bothering, of demanding more than she can give; may act bored, preoccupied, or hostile; may berate herself for emotional weakness .
- The therapist may experience herself as unwanted, unimportant; may try harder to reach the patient and feel frustrated, inadequate, enraged and depressed. The therapist may be tempted to give up, withdraw, or even refer or terminate.



GUIDELINES FOR CHANGE IN THE FRAME

- **Consider theoretical basis for change**
- **Discuss change in depth with the client**
- **Discuss and observe the impact over time (with or without the change)**
- **Make use of consultation: assess potential for uncovered reenactments**

MORE GUIDELINES ABOUT COUNTERTRANSFERENCE WITH DISSOCIATIVE CLIENTS (Pearlman and Saakvitne)

- **The therapist must hold onto conceptualizing the client as a whole: one person who has a fragmented self identity**
- **The therapist must be careful to notice different responses to different aspects of the client, positive and negative**
- **The therapist must be careful to notice her own ambivalent dissociated self responses to different parts of the client**
- **The therapist must remain aware that all parts of the client's self identity (difficult, intimidating, dangerous, self injurious, or sweet and compliant) are all an attempt to adapt and cope with the overwhelming situation of the past original experience.**
- **The therapist must avoid colluding in the wish or belief that any one part of the client's self should be destroyed**
- **The therapist must notice and experience her own strong feelings in response to the work**
- **The therapist must avoid doing this work alone, and seek consultation as well as restorative experiences with others**
- **The therapist must know when it is too much and be willing to talk about that with a consultant**
- **The therapist must be both willing to continue and willing to stop with any one client or with these types of client's**



ASK THESE QUESTIONS

- 1. Can you say that you Do No Harm?**
- 2. Can you say that your patients are better off with your help? Do you provide psychological first aid?**
- 3. Do you feel your work helps contribute to harm reduction?**
- 4. Can you problem solve alone or with your collective to think of ways to do more harm reduction?**
- 5. What issues in your professional life and situation parallel the lives of your patients?**
 - Feeling powerless**
 - Anger**
 - Double binds**
 - Secrets**
 - Splitting**
 - Shame/guilt**
 - Hopelessness**
 - Feeling overwhelmed/hyper aroused**
 - Other _____**



**“DISSOCIATION IN THE THERAPY CAN
REVEAL COMPLICATED INTERACTIONS THAT
OCCUR BETWEEN TWO PEOPLE AND
BETWEEN THE PAST AND THE PRESENT”**

(Pearlman and Saakvitne, p.138)

The Goal of Therapy is to make explicit and conscious:

- **The client’s need to flee the therapist**
- **The client’s need to hide from the therapist**
- **The client’s need to protect the therapist**
- **The client’s need to disempower the therapist**

**The Goal is to understand where and when and with whom
this comes from in the client’s original story**

THE JOB OF SORTING OUT:

- **Notice What is happening, or just happened**
- **What stimulated or triggered it to happen**
- **When did it ever feel that way before**
- **Who did this happen with before, and/or first?**
- **Go Slowly and carefully/ develop ways to talk about**
- **Use the dissociation to remember and reveal**
- **Use the transference revealed when it is safe to use**
- **Use the countertransference to get to the original
experience *most carefully***



WHAT MAKES A CASE UNWORKABLE?

- **ANTISOCIAL PERSONALITY TRAITS**
- **MUNCHAUSSSEN'S TYPE INVESTMENT IN THE SYMPTOMS**
- **OVERLAPPING SYMPTOMS THAT MAKE IT COMPLEX/UNTREATED COMORBIDITY**
- **IMPENETRABLE TRANSFERENCE/COUNTERTRANSFERENCE**

SO, THEN WHAT?

GET CONSULTATION in order to Help client TERMINATE the work within a 6 month period.

IMPORTANT INFLUENCE:

The developmental work that the patient and the therapist have experienced in the past influences what they can do together developmentally in the future.

| |
|--|
| THE THERAPIST PROCESS IN TREATING DISSOCIATIVE DISORDER AN EVOLVING MODEL |
|--|

Continuum Process

| Neophyte | Mastery Phase | Expert Phase |
|----------|---------------|--------------|
|----------|---------------|--------------|

1. Neophyte

Characteristics:

1. feels overwhelmed
2. feels inadequate
3. often feels urgency to keep client in treatment
4. feels pressured by client and has difficulty with boundary issues
5. may feel indispensable to patient
6. feels responsible for patient's progress
7. often feels angry at patient
8. feels isolated
9. PTSD symptoms

Common Pitfalls:

1. runs risk of becoming overly invested in the client
2. undefined roles
3. may collude in continued fragmentation of the system by talking to a favored alter believing it is possible to keep secrets

2. Mastery Phase

Characteristics:

1. more aware of counter-transference issues
2. can articulate therapeutic expectations
3. sees patient as a whole system
4. understands the fragile nature of the therapeutic relationships
5. can better manage internal conflict and ambivalence

TERMINATION: SAYING GOODBYE IN TRAUMA THERAPY

We're very happy to have this job. Termination is the cost.

- Dr. Jean Goodwin

Look for and review:

In this process, we're learning to be the ex-therapist. We're going through everything they are going through, including primitive fantasies.

According to Freud, therapy is the ability to work and love. What was the person able to do workwise and love wise at the beginning of your time together???

According to Basch, therapy is about improving perception, understanding and coping. Look for a parental interaction/experience that has been improved.

According to Linehan, therapy is about increased mindfulness, self-soothing and assertiveness.

According to Perlman, therapy is about sustained positive self regard, the ability to tolerate strong feelings and sustained connection with others.

Know that . . .

This process will include a full, rich spectrum of emotions: sadness, tears, anger, rage, fear, worry, relief, terror, love (all the transferences thereof), joy and laughter.

Traumatic attachment is very powerful.

All phases of attachment and autonomy will happen.

Ritual, according to Ono Van Derhart, is: planned; has at least one witness; a symbolic object is exchanged, enshrined or destroyed; and a celebration follows.

Stuckness may be a refusal to grieve . . . "I don't care how you say it, even if you don't mean it" Rosie from "Fearless".

New memories are a good sign. When reenactments stop, memories begin.

There is always a fantasy that a termination isn't needed. Resistance may be seen as regression, increased symptoms or impulses, acting in, acting out, splitting, denial (primitive defenses), somatization, confusion about ending date, diversion, displacement, escape into fantasy, reenactment of prior grief and loss, increased interest in the therapist as a person.

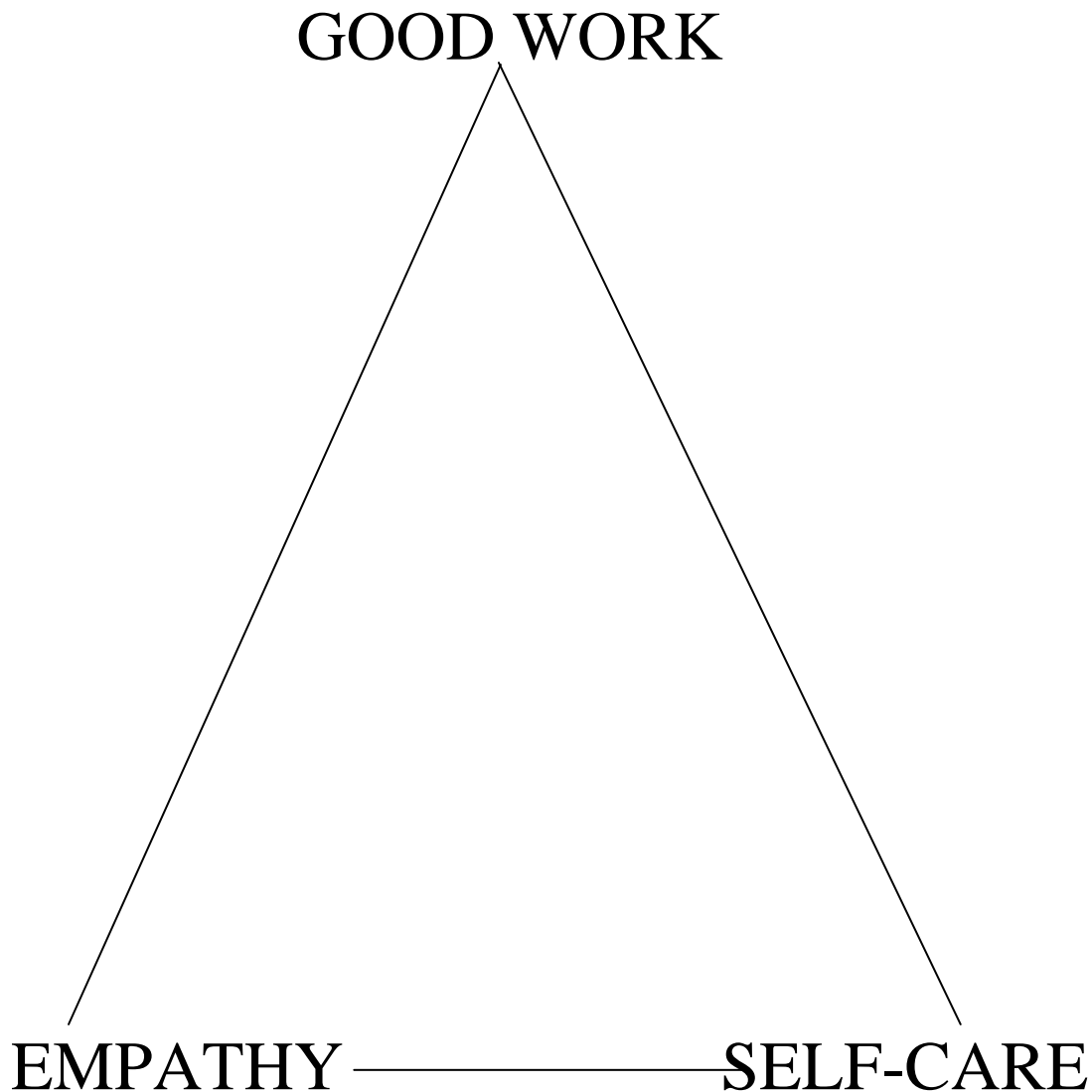
The core conflict will reemerge in a more crystallized form. (Review the first three sessions to grasp the core conflict. Think about where the client is developmentally.

Questions, mindset of short-term, solution-based therapy may be helpful with some clients.

You need to be clear about what the continuance options are, private practice and fees???

The Healing Triangle (Harvard Program in Refugee Trauma, 2008)

WHAT HELPS OTHERS and YOU?



Transference and Transference Responses

Pearlman and Saakvitne, 1994

4 Classic Double Binds (Waites, 1993)

1. contact is necessary for survival / contact is dangerous
2. attachment is desirable /attachment is disappointing
3. attachment is pleasurable/love means hurting
4. attachment is good/love means total surrender

These early templates for attachment and dependence are at the root of the conflicts evoked by the therapy relationship and its' invitation to closeness.

It is the clinician's ability to assume, enact, observe and to help make explicit all of the relational stances taken by each member of the dyad, without becoming locked into any particular role of dynamic reenactment.

Two counter transference identification mechanisms:

1. **Concordant Identification:** direct identification with the client and her affective or transference experience. A parallel response to the client's present experience, the therapist shares the client's feelings, attitudes, and judgments and reflects them back (anger for anger, hate for hate). The therapist can know what the client has felt.
2. **Complementary Identification:** responsive identification with the role demands of a client's affect. The therapist identifies with the "other " the transferred parental other, and has feelings complementary to those of the client and consistent with those of the abuser. The therapist may be perceived as critical and sadistic, the therapist may feel critical and contemptuous of the patient. It is relieved.
 - Transference responses have been organized in accordance to various constructs: arrested development
 - Self psychology needs,
 - Object relational paradigms
 - Ego libidinal phases

ALSO: three Major Areas in which one can expect transference reactions:

1. The client's need for the therapist to supplement inadequate self capacities, specifically limited capacity for tolerating feelings, object constancy and self esteem maintenance.
2. **Frame of reference:** transferences related to the client's fundamental identity and world view and spirituality. Reflect the client's core experiences and related expectations, her wishes and fears about self, other and the world.
3. Transferences informed by an individual's salient psychological needs and schemas about safety, esteem, trust and dependency, control, and intimacy for herself and others.

All three of the above reflect the repetition of feelings and conflicts from early object relational experiences.