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Countertransference & transference crises in working with traumatized patients
The making of good therapists

- The rise of the EBTs
- BUT, the “common factors” account for up to 9 times the variability in outcome as do the specific techniques

Nonspecific factors

- value/goal congruency (Division 29 Task Force, 2001)
- clarity of rationale for therapy (Wollershein, Bordewick, Knapp, McLellam, & Paul, 1982),
- warmth/caring (Division 29 Task Force, 2001; Orlinsky & Howard, 1978)
- credibility/trustworthiness/genuineness (Division 29 Task Force, 2001; Orlinsky &
The study of the common factors takes many forms

- Alliance
- Alliance rupture
- Factors that prevent the client from forming the alliance or that disrupt the alliance
  - Transference issues
- Factors that interfere with the alliance and impede progress from therapist side
  - Countertransference issues
The transference story

- The client shows a reaction in the therapeutic situation that the therapist believes is inappropriate
- The therapist makes an interpretation
- The client accepts the interpretation and is able to moderate behavior that had been fixed or difficult to moderate before.
The countertransference story

- The client performs some behavior, usually provocative (boundary press, suicidality, anger)
- The therapist reacts, at times rationally and at times based on past experience
- Thinking about the behavior later, the therapist labels his/her own reaction countertransference
- The therapist takes some reparative action.
The definitional dilemma

- You, the patient, have a transference issue if I, the therapist, say so.
- I, the therapist, have a countertransference issue if I, the therapist, say so.

Expertise versus objectivity
The obvious and the vague

- Do not sexually abuse your patients
- Do not take them home with you or take over their lives
- Do not become their financial advisor
- Protect their confidentiality
On the back of a bag of peanuts

Ingredients

Peanuts (100%).

Allergy advice
Contains peanuts.
Not suitable for nut and sesame allergy sufferers due to the methods used in the manufacture of this product.
How I learned what is wrong with the countertransference literature from my digital camera manual

- Instructions not to do things that it would never occur to me to do
  - Do not immerse in water
  - Do not disassemble
    - Do not sleep with your patients
- Instructions not to do things that I only do by accident and would never do consciously.
  - Do not drop
    - Do not unintentionally violate the emotional boundaries of your patients
- Instructions that need instructions
  - Do not overfocus
    - Create safety for your patients.
The vague

- Do not gratify the patient
- Do not do anything that makes the patient feel unsafe
- “Do not unintentionally violate the emotional boundaries of your patient.”
The ethical slippery slope

- Don’t sexually abuse
  - So don’t react positively to sexual material
  - Don’t acknowledge flirtation
  - Refer those who are sexually interested
    - Don’t get too close
    - Don’t disclose
    - Don’t think about your own sexual feelings
      - Don’t care too much
      - Don’t react strongly
      - It is a “burden” to the patient if you react at all
      - Shut down and emotionally leave the room
What happens when you tell the therapist to be emotionally avoidant?

- The therapist will begin to encourage the client to be more avoidant (Fawcett, 2009)
- The dynamic will reverberate, and the client will be more avoidant
- The therapist will become more dissociative
- The alliance will begin to suffer
Nondisclosing therapists

- 12% of the clients claims that their therapists never showed anger at them.
- These clients were more likely to agree with a statement that anger disclosure was inappropriate in a therapist.
- They were also more likely to report believing that it was part of the therapist’s job to experience client anger without retaliation or emotional reaction.
- This group had a lower positive symptom change than did the rest of the sample.
Our questions

- How do you negotiate boundaries with a person for whom boundaries is a traumatic subject?
- How do you repair the inevitable disruptions that will come when you DO make the patient feel unsafe and violated?
- How do you ethically and humanely deal with a sexual transference?
53.3% of psychologists had been so afraid of or for a client that it affected eating, sleeping and concentration

46% had been so angry that they did something they later regretted

57.9% had experienced sexual arousal with a patient
Why crises occur with traumatized clients

- The greater intensity of traumatic transference
- Problems of continuity produced by failures in memory (dissociation)
- Problems in responsibility produced by failures in connection to the self
Did you ever feel great or intense love or great/intense hate toward your therapist?
Dissociative clients

- Were more likely twice as likely to report that they had felt great love toward their therapists.
- Were more 1.7 times more likely to report that they had felt great hatred toward their therapists.
- Were 2.9 times more likely to say that their therapists had scared them badly at least once.
What do you think was the source of your hatred?

- Unsatisfied patients
  - S/he didn’t care.
  - S/he wasn’t competent (didn’t help)
  - S/he didn’t believe me.
  - S/he didn’t take my side.
  - S/he put his/her needs above mine
What do you think was the source of your hatred?

- Satisfied patients
  - S/he had power over me and wasn’t sufficiently aware of it.
  - Arbitrary boundary change
  - S/he wouldn’t do X and didn’t see it as a problem for me.
  - S/he didn’t understand something important about me.
  - S/he didn’t take my pain seriously enough (e.g., didn’t seem to worry about me)
Hating love

- Hating the new vulnerability it brings
- Hating the disequilibrium it brings
- Hating changes in boundaries
COUNTERTRANSFERENCE
CRISIS #1: MY THERAPIST WAS DISTANT/DIDN’T LISTEN
Did you ever feel completely unknown?
Written in pencil in the sealed freight car

Don Pagis

Here in this transport
I, Eve
and Abel my son.
If you see my older son
Cain, son of man
tell him that I
Statements by reporters and politicians regarding the Sept. 11th attacks

- It’s..it’s..I can’t tell you what it’s like..it’s just..I can’t tell you what it’s like here.
- Standing here, it’s overwhelming..I can’t tell you how much..it’s staggering.
- My reaction to what happens was so…(long pause) I don’t know how to describe it…tumultuous.
Describing trauma

In the terrible years of the Yezhov terror, I spent 17 months waiting in line outside the prison in Leningrad. One day someone in the crowd identified me. A woman, lips blue from cold, who, of course, had never heard me called by name before.
Anna Akhmatova Il

She started out of the torpor common to us all and whispered – everyone whispered there – Can you describe this? And I said “I can.” And something like a smile passed fleetingly over what had once been her face.
When language fails, what can be its substitute?
When Harriet Beecher Stowe told the story of the slaves, as black poet Paul Laurence Dunbar put it,

“The whole world wept
At wrongs and cruelties it had not known”
Listening to trauma

P: She [her therapist] just would not listen. She kept shifting the subject. I would be trying to figure out how to tell her something and she would cut me off. It hurt so much.

Int: How would she cut you off?

P: She would not let me speak. She would ask me about something else. I think she must have thought I was to blame for the rape (Begins to cry)

Int: Did she say anything like that, that you were to blame?

P: She didn’t say much at all, really, except for the questions. She was so..silent. That’s part of why I think she was ashamed of me.
Dr. B: She just couldn’t talk about it. I tried to make it easier for her, you know, did all the usual things

Int: What usual things?

Dr. B: I tried to support her defenses while they were still needed. I respected her silence. I could tell the whole thing was too much for her. I actually feel very badly about it. I don’t usually have clients leave this way.

Int: I understand. How did you respect her silence?
Dr. B: I knew that she was not able to talk yet, and I understood that. It was a really terrible rape, from what I could tell about it. I knew she was ashamed. I know I didn’t deal with it well.

Int: What do you think you should have done?

Dr. B: Interpreted her resistance, probably

Int: Ok, well, I’m not saying that I think you should have done that, but why didn’t you do that?

Dr. B: I felt sort of..incompetent..from being faced with that much pain. It threw me off.
Why they think you are silent

- Because you are waiting for them to speak
- Because you are judging them
  - For their actions at the time
  - For their inarticulation at present
Why you are really silent

Reason 1:
Because you are vicariously traumatized yourself
Why you are really silent

Reason 2:
Because you are trying to think of something profound to say
Why you are really silent

Reason 3:
Because you are empathically connected to the client’s wish to avoid
The wish for an authentic response to the trauma: Dalenberg CT study participant

S: I found myself shaking. Really shaking
Int: As you told your Vietnam stories
S: As I told one story
Int: Do you want to tell it first?
S: [retells story: deleted at pt request]
Int: It makes me shake just to listen to that. What did your therapist do with it?
S: (tearfully) Nothing. If I heard “uh-huh” one more time I was going to deck him.
Authentic response II

Int: Uh..oops
S: (laughs) Habit, huh?
Int: (laughs) So you didn’t deck him. What did you do?
S: I sat there quivering like a jackass, well, like a rabbit..like a child, really. It was..what’s a bigger word than embarrassed…and mortifying. How’s that? Mortifying. Does your tape recorder work? Write that down.
Controlled inaccuracy

But then she proceeds, as if in pursuit of a controlled inaccuracy, not as a calculated breach of truth, but as a concession to what words cannot do, an assent to the partial collapse of verbal power.

Langer, 1991
Joseph F: Participant in Dalenberg countertransference study

- I guess the most helpful thing my doctor did...well, this is going to sound strange, but he tried to guess what it must have felt like to me as a kid. And when he was groping around for the words he just hit on a couple that worked. And until that happened, I couldn’t grip them with my mind, you know? They kept slipping away. His descriptions weren’t exactly right, but they were like sandpaper. My own truth stuck to his words well enough for me to trap it and talk about it.
COUNTERTRANSFERENCE
CRISIS #2: PROOF OF CARE
Proof of failure to care

Evidence of a failure of care
- A nondisclosure
- Not chasing the avoidant client
- Forgetting or cancelling a session
- Not following up on an issue
- Not questioning suicidal ideation
- Hospitalizing or not hospitalizing
- Becoming angry
Why does the proof of care issue come up so often in traumatized clients?

1. The feeling of unreality leads to a wish for physical proof of care.
2. The lack of consistent caretakers or a recent betrayal by a trusted other leads to a wish for physical proof of care.
3. The inability to sustain a soothing image leads to a wish for physical proof of care.
4. Episodes of acting out lead to a wish for proof of alliance repair.
5. Intense shared suffering produces feelings of closeness.
Benny’s warning

Benny: You can’t go, you can’t go to New Zealand
T: I can’t?
Benny: No, because you know what?
T: What?
Benny: My mom, my mom she has pictures and magazines at her office
T: Yeah?
Benny: And do you know what?
T: What?
Benny’s warning II

Benny: There’s… New Zealand is right next to Austria.

T: It is?

Benny: Mm-hmm. And there’s kangaroos in Austria and if they kick you, you’ll die.

T: Benny, if I see any Austrian kangaroos in New Zealand, I will be very careful.
THE ODDNESS OF THERAPY
Did you ever engage in risky behavior to get someone to react: Dissociative sample

![Bar chart showing the comparison between General and Therapist responses regarding engaging in risky behavior to react. The chart indicates a higher percentage of 'Yes' responses for General compared to Therapist.]
Don’t be a blank screen

- Honest countertransference disclosure helps the crisis patient to understand that your frustration is not disdain, your exhaustion is not boredom, and your use of avoidance when you are terrified for your client are not withdrawals due to lack of interest.
- Tell them what they can do to let you sleep nights.
COUNTERTRANSFERENCE
ISSUE #3: THE BOUNDARY SHIFT
The boundary shift

- Not that your boundaries are too firm, or too weak, but that they shift
  - And angry client’s outbursts eventually become too much for the therapist
  - The number of calls becomes overwhelming over time
  - A personal boundary violation by the patient feels too serious
  - The belittling or dismissal of your interpretations or suggestions gets old
The blame boomerang

- The client presents with pervasive self-blame
- The therapist fights self-blame with other-blame
- The client, feeling supported by this stance, escalates other-blame in her external life
- The crisis
  - Extreme and endangering other-blame
  - Other-blame turns toward the therapist
- The therapist confronts the client regarding her other-blame
- The client feels betrayed
Lessons from Allen, 2008

- Therapists think anger is more pathological when it is aimed at them.
- Therapists often do not apologize for their errors, or do not apologize in a way that is felt as sincere by patients.
### Ambivalence regarding patient emotion

<table>
<thead>
<tr>
<th>If it’s directed toward your loved ones or colleagues</th>
<th>If it’s directly toward me</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can’t help it or you shouldn’t have to control it, and others should have compassion</td>
<td>It’s not healthy, you should control it, and you should have some compassion</td>
</tr>
<tr>
<td>Expressing your anger is a healthy response and a cure for depression</td>
<td>Your hostility toward me is getting in the way of my being helpful to you</td>
</tr>
<tr>
<td>Depression is a disease, and others should have compassion</td>
<td>I think you’re over-responding here because of your past</td>
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The Hostile Apology

I am sorry you reacted the way you did. I didn't intend for you to feel badly. (Translation to most clients: I am sorry my small action caused you to have such a neurotic fit).

The True Apology

I was thinking this when it is probably more true that the world looks like that. You are right., and I screwed up. I'll try to learn something from it and not to do it again.
Careful..

- Crisis is not always short-term
  - Do not make promises to crisis patients that you do not plan to keep very long
  - Never ask a patient, but particularly a crisis patient, to do something that involves an exploitation or misuse of you.
Correlations with time to reported stabilization in extremely dissociative patients

- Severity of trauma (rated): .17*
- Number of perpetrators: .19*
- Severity of dissociative Sx: .24*
- My therapist was both annoyed & caring when I would make a lot of demands: .54**
- My therapist was good at apologies: .70**
MAKING THE STRUGGLE OBVIOUS
I really really needed him and he said that he didn’t return phone calls after 8, that if I kept calling him after 8 that I’d have to get someone else, and I thought “God, I can't put my pain on a schedule for you.”

CONTRAST THIS WITH

I was calling her a lot, a real lot, and she sat me down and said “Jenna, we have to figure out how to get both of our needs met here. I know you need me, but I have to get some recharging time, so what should we do?” It was really respectful.
Availability statement

I am not a full-time clinician. I teach, travel and testify, all of which consume blocks of time that lead me to be unavailable for periods during each week. If I plan to be out of town for more than a day, I will tell you about it even if it does not effect your appointment. If I am in town, I check my voice mail a few times each day. I will return your call.

I know that it is difficult to imagine at the beginning of therapy, but hopefully there will be a time that you will be bursting to tell me some new thought you have about what you are discovering about yourself. Your pain or your excitement or your pleasure at discovery may be so great that you will wish immediacy from me. It will feel like we need to talk now. This is a part of the work, and it can be a great part, but from the beginning we need to negotiate it.

Keep me informed about what you need.
Hostile or explosive disclosure

She was unwilling to accept my apology and, despite my efforts to open this for discussion, she was absolutely unyielding, unwilling to consider anything I might say, and self-righteous about her position…I insisted that on the basis of our work so far, though she seemed to feel she had the “right” to now wipe the floor with me, I had at least earned the right for her to consider that my canceling the session might not have been frivolous or uncaring or irresponsible. Furthermore, if she felt she couldn’t give me the benefit of the doubt, and even forgive me, then I felt that I had as much right to be angry at her as she had to be angry at me. At this point I told her that I had actually canceled to go to the funeral of a friend. (Ehrenberg, p. 71)
What did you ask your therapist about?
How did you feel about his/her response?

![Bar Chart]

- **Canc**: Neg Disc - Neg Refusal
- **SexO**: Neg Disc - Neg Refusal
- **Opts**: Neg Disc - Neg Refusal
- **TH**: Neg Disc - Neg Refusal
I could, of course, run out of the office screaming (a course of action that seemed most in keeping with my affective state). I could be silent and mysterious in the same way my analyst was with me. I could explain to her that her feelings were a form of resistance to the therapy and tell her to stop having such feelings. I could fake a nosebleed and tell her I'd be right back after tending to it. (That would at least buy some time to think.)

I said to the patient, "Well, this sort of thing happens quite frequently in therapy."

Stake and Oliver, 1991: Response to sexual feeling

- Acted on it: 1.3%
- Told client: 17.1%
- Discussed w/ therapist: 18.8%
- Discussed w/ supervisor: 49.3%
- Referred client: 22.1%
- Worked through by self: 69.5%
- Never felt it: 15.4%
Therapist responses to sexual transference: Categories negatively evaluated by patients

1. When in doubt, kick it back
   1. Therapist asks what patient means by some term or wonders how patient feels about not knowing what therapist feels

2. Donning the cloak
   1. Therapist becomes intellectualized and withdraws, usually making a distancing interpretation.

3. Calling in the cops
   1. Therapist tell patient that sexual feelings are inappropriate in therapy or subtly/obviously threatens to leave if client does not change his/her behavior.
Case example: Sexual transference
Slide 1

- C: You look nice
- T: Thanks
- C: Why’s that on already?
- T: I wanted to play one of our sessions for my supervisor because you were saying that we were stuck
- C: I just wanted you to tell me I’m pretty. What’s so terrible about that?
T: It’s not terrible. But it’s not what I’m here for
C: I love you. You…when the tape isn’t going you’re warmer
T: I’m sorry. But we can’t do anything sexual. You know that. I’m trying to figure out how to get on with things
C: It’s me that has to live with it. Why can’t you just be glad I love you. Why do you have to make me feel so horrible about it?
T: Because I know it’s not me you love. It’s this whole experience.
Differences between successful and unsuccessful therapies: What did your therapist feel about your attraction?
Therapist responses to sexual transference: Categories positively evaluated by patients

Self-disclosure with role statement
Therapist discloses positive or conflicted feeling regarding the client’s feelings but states that no sexual involvement will follow
Example of unsuccessful resolution

How did the issue come up?
He kept asking me again and again whether I had any sexual feelings toward him. He interpreted my dreams as veiled sexual statements, which I didn’t agree with. Finally, I just agreed with him, and convinced myself that I felt it. I was really pleased when I began to feel it. I thought it was progress.

How did he react?
He immediately said that I should know that there would be no sexuality between us no matter how provocative I was, that this was transference.

How did you feel?
I was pretty humiliated. I asked him how he felt about me, whether he was angry or thought less of me, and he said his feelings were not relevant, but that we might talk about what I expected him to feel. I’ve never felt so alone and humiliated in my life.
Example of successful resolution

How did it come up?
I told him about it after about a year in therapy. He had kind of warned me earlier

How did he react?
He was very sweet. He said that this was a hard part of therapy, and that two good people like us were bound to feel warmly toward each other after all this intimate time together. He said that it could be a positive for us, so that we felt good and attractive in each other’s company, and the only negative would be if either of us decided to focus on changing the basic goals of the relationship we were in.

How did you feel?
Well, I was scared to bring it up, but he was so…I don’t know, kind of gently worried about it, like of course we would both feel that way but we have something important to defend. I was so glad that he could accept me as a sexual person but that that wasn’t the most important thing in his life. It was probably the most important interaction we had.
When not to touch

- The touch has an aura of secrecy
- The therapist feels manipulated
- Client does not give permission
- Touch is replacing words
- Therapist doubts client’s ability to say no
- Sexual contact has been recently discussed
- Touch is not for the client’s benefit
- Touch is mismatched with the level of development of the relationship
- No time remains in the session to adequately process the touch
Touch refusal

You know [Name], I really understand your wanting to do that. It actually feels soothing to me too, the two of us holding hands when we’re so scared. But you know how sometimes when you’re in an auto accident and they won’t give you morphine at first until you can tell them where it hurts? [P nods] Well, I think of touch like that sometimes. It soothes us so it doesn’t hurt so much and it can make you less able to really explain what’s happening inside. I’m right here. I won’t go anywhere. But I want you to just try to talk about it without holding my hand.
Going from here

- At this point, I believe we need two shifts in foci. First, we need both a partial shift in focus for the case presentations of expert therapists, giving more time to the method used to build and support the relationship in contrast to the method of producing symptom relief.
- Second, we need a set of researchable questions within the area of empirically supported techniques of relationship enhancement and alliance-building.
Training implications

- It’s not enough to tell therapists “here’s a list of things you shouldn’t do” or “be careful not to exploit your clients.”
- Therapists need to learn when to say yes, and how to say no.
What should supervisors be doing?

- Supervisors should discuss with therapists professional ways to check in with patients about the degree of warmth, genuineness, and trustworthiness.
- Common questions asked by trauma clients should be discussed with trauma therapists.
- The attention of supervisors should be focused not only on technique, but also on the therapists’ individual level of warmth, genuineness, and implied trustworthiness.
- Extended discussion of the rationale for the treatments being provided should occur in supervision.
What should researchers be doing?

- Researchers should consider tests of training models aimed toward enhancing the clinician’s ability to promote the common factors.
- The common factors could be seen and researched as interactional in nature, rather than as properties of a given clinician
  - (a) behaviors that enhance the experience of warmth
  - (b) client characteristics that impede the experience of being in the presence of warmth, when it is offered.
Conclusion 1

- Enhancing our effectiveness with the traumatized population, therefore, involves not only encouraging research on innovative techniques for changing affect and thought patterns in clients, but also developing research protocols that test methods of improving and protecting the working alliance between trauma therapist and traumatized client.
Conclusion 2

Finally, I recommend more research that focuses on listening to the client as they discuss the emotional experience of being in various types of trauma therapy, and solving common countertransference and transference crises.
Even miracles take a little time

--Cinderella’s fairy godmother
THANK YOU
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