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Transference and Countertransference:


- Transference (Freud): Unconscious feelings of the patient, based on past genetic relationships, that get projected onto the therapist
- Countertransference (Freud): Unconscious feelings of the therapist, based on past genetic relationships, that get projected onto the patient
- Broader definition: Any feeling, unconscious or conscious, that is identifiable to both patient and therapist

A diagram showing two human heads in profile, facing each other. A thin arrow points from the left head to the right head, and another thin arrow points from the right head to the left head, illustrating the reciprocal nature of transference and countertransference.

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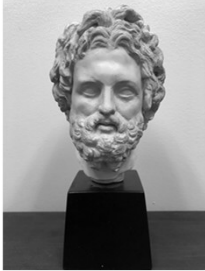
The Wounded Healer

Greek myth of Chiron the centaur: Chiron was physically wounded, and by way of overcoming the pain of his own wounds, became the compassionate teacher of healing.

A black and white reproduction of a classical Greek vase painting. It depicts Chiron, a centaur, standing and holding a bow and arrow. He is shown in a human-like form with a horse's lower body. The background of the vase features decorative patterns.

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The Wounded Healer: Asklepios – Greek God of Healing



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The Wounded Healer

At least one study has shown empirical support for this notion with the finding that 73.9% of counselors and therapists identify one or more “wounding experiences” as influencing their career choice*

* Barr A. An investigation into the extent to which psychological wounds inspire counselors and psychotherapists to become wounded healers, the significance of these wounds on their career choice, the causes of these wounds and the overall significance of demographic factors. Masters Thesis, University of Strathclyde Counselling Unit, Glasgow, Scotland; 2006.

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Countertransference: We are not machines



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Countertransference stages:

Stage 1. Denial



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Countertransference stages:

Stage 2. Reluctant acceptance



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Countertransference stages:

Stage 3. Acceptance



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Countertransference stages:

Stage 4. Embracement



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Countertransference: "Red Flags"

- Believing that your relationship with the patient is "special", and not subject to the usual rules of professional conduct. This can also include believing "I am the only one" who can help the patient.
- Doing something with the patient outside of the normal therapeutic activity (something that you do not do with any other patient). For example, walking them to their car, becoming friends on social network, or giving them your personal phone number.
- Dreaming about the patient, especially if this occurs more than once.
- Daydreaming excessively while in the therapy session, being mentally "outside of the room" for extended periods of time.

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Countertransference: "Red Flags"

- Dreading seeing the patient's name on your schedule or hoping for their cancellation. Alternatively, looking forward to the session, especially to tell the patient something about your life.
- Having intense feelings about the patient or therapy session that stay with you well beyond the therapy hour. This can include having frequent fantasies about the patient.
- Keeping something from the therapy secret or hidden from psychotherapy supervision.
- Initiating contact with the patient outside of customary procedures.

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Safe supervision



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Countertransference: Therapist sharing feelings

- Anger
- Fear
- Confusion
- Like

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Countertransference: disclosure example

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Bob is a shy, socially anxious, intelligent young man and has been in supportive psychotherapy for several years. He was severely bullied in adolescence, to the point he dropped out of school and became socially phobic. The therapist genuinely enjoys Bob's perseverance, wit, and kindness to others which are especially admirable given his childhood abuse. Bob admires the therapist and feels safe with him.

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Bob: "I'm just too nervous to join that group. I feel like people in general don't like me. I don't even like myself very much. What is there to like?"

Therapist: "We've talked about this before Bob. Together we have looked at so many things about you that are likeable. Are you having trouble getting in touch with what you like about yourself...feeling it at this time?"

Bob: "I know, I know. I can say those things but I still don't like myself, and I don't feel like people like me. Do you like me?"

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Therapist: "Bob I really can't answer that question for professional reasons. Let's take a look at what you feel about yourself instead."

Therapist: "Yes Bob, I do like you. You have so many good qualities it is easy to like you. I think what is most important, however, is that we need to keep working on you liking yourself. That is our challenge. I think when you like yourself better it will be easier to believe that others like you."

Therapist: "I can understand your question Bob, but I need to shift the focus on what you feel. What is most important is that you like yourself. We have talked about your many likeable traits, however, you have a hard time believing these. We need to understand better what stops you from believing in yourself."

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Strategies and Techniques

- Listening (including “active”
- Plussing
- Explaining behavior
- Normalizing
- Encouragement

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Strategies and Techniques

- Reassurance
- Hope
- Metaphor
- Telling stories
- Coping skills

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Strategies and Techniques

- Reframing
- Anticipatory guidance (“lending ego”)
- Self-soothing (educate)
- “Striking while the iron is cold”

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Strategies and Techniques

- Humor (**use with caution**)
- Comparing pain (generally avoid)
- Writing it down
- Writing the letter you will never send
- Patient consultation

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Trauma

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Trauma

Nietzsche: *"That which does not kill us makes us stronger"*

Battaglia: *"unless you are traumatized by the experience"*

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Adverse Childhood Experiences (ACES)

- Physical abuse
- Sexual abuse
- Emotional abuse
- Neglect
- Witnessing domestic violence
- Victim /witness to violence
- Community violence
- Serious medical illness/procedures
- Bullying
- School violence
- Disasters
- Traumatic grief/separation
- Incarcerated parent
- Historical violence
- Military trauma
- War
- Terrorism
- Political violence
- Forced displacement (political persecution)

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Trauma changes a person

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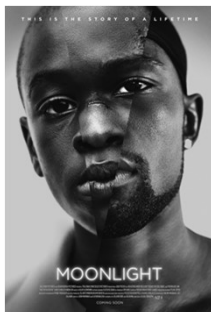
Working with trauma:

- Assume the symptoms make sense (are not "crazy")
- Symptoms provide safety in some way
- Symptoms were adaptive at one time
- Symptoms prepare the person to withstand further trauma

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Doug is a 4-year-old boy who was raised by a mother with schizophrenia. He underwent a number of traumatic experiences when his mother was psychotic, paranoid, and agitated. He was eventually taken from his mother by child protective services and placed in a foster home. One morning the foster home parent was sick with a cold and told Doug, *"I'm feeling sick today Doug, I need you to be especially good because I'm too sick to deal with problems"*. Sometime later that day Doug's foster parent called the mental health clinic for help with Doug. *"He has been hiding in the backyard for hours and won't come inside. I don't understand this, nothing bad has happened and he seemed perfectly normal at breakfast. I even made him his favorite lunch but he refuses to come in"*.

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Two stories about trauma

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Supportive Psychotherapy for PTSD

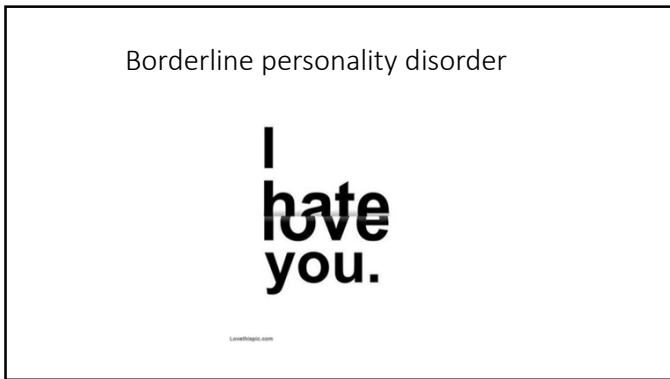
- Education about PTSD (including flashbacks and "ripple effects")
- Good therapeutic alliance (correlated with successful PTSD treatment)
- Safety and coping measures
- Problem solving techniques
- Re-framing cognitive distortions
- Discussing the trauma (or not)
- "After hours" techniques for grounding, social support, medications
- EMDR* (Eye-Movement Desensitization and Reprocessing)

*Shapiro, F. Eye Movement desensitization: A new treatment for post-traumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry*. 1989; 10 (3); 211 – 217

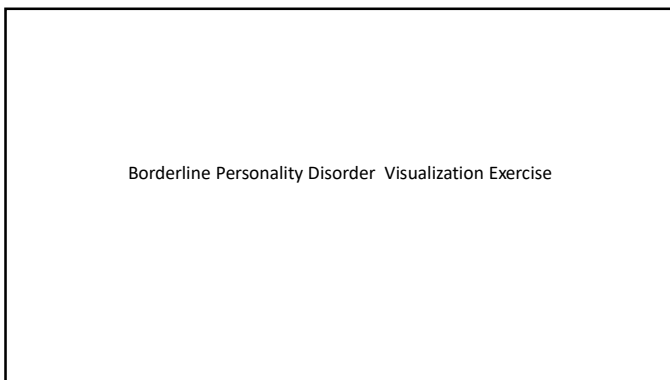
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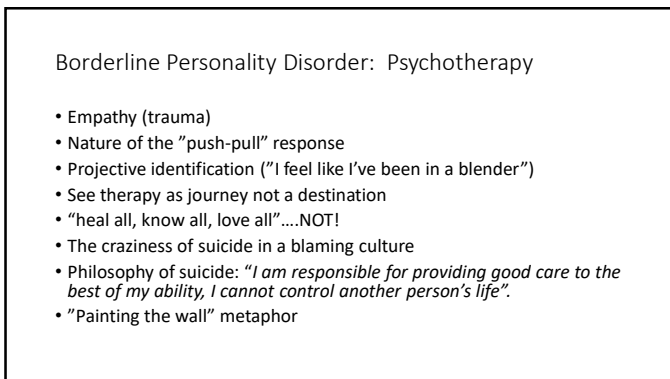
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Borderline Personality Disorder: Psychotherapy

- Education
- “No-fault” brain diagnosis
- Good boundary maintenance (corrective emotional experience)
- Consistency and strength (“I can take it”)
- Strike while the iron is cold
- DBT*: identify mood states, mindfulness training, distress tolerance skills, interpersonal effectiveness training

*Linehan, MM. Cognitive-behavioral treatment of borderline personality disorder. The Guilford Press, New York. 1993.

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Supportive Psychotherapy: Substance Use

- Mutually exclusive...contradiction in terms?
- Good boundary maintenance – no sessions while intoxicated (neutral, non-threatening, non-punitive response)
- Expect deceit... and shame
- Handle relapses expectantly
- Explore craving
- Don't get too excited with sobriety (less than a year)
- Confrontation...Socrates style (Meno's slave)

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Supportive Psychotherapy: Substance Use

- *What does the substance do that doesn't happen without it?*
- *What does it allow?*
- *What things are more easily avoided?*
- *What pain is avoided?*
- *What is good about using?*
- *What do you like about it?*

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A final note:
