Countertransference

Whenever therapy becomes intense, as in crisis work, the potential for countertransference rises dramatically. **Countertransference** is the attributing to the client, by the crisis worker, of traits and behaviors of past and present significant others or events in the crisis worker's own life. Countertransference responses may be positive or negative, spoken or unspoken, conscious or unconscious. They may include physical, psychological, social, gender, racial, moral, spiritual, cultural, or ecological factors that have impacted the worker through past experiences and are manifested in the "here and now" of therapy by the client. At times, emotional aspects of the client may agitate feelings, thoughts, and behaviors that are deeply buried within the worker's own personality.

When confronted with their own shortcomings, fears, faults, prejudices, and stereotypes as mirrored by the client, human services workers may begin behaving in inappropriate ways. Workers may act in ways designed to meet their own needs and not the clients'. The result is that clients are made to fit neatly into the workers' preconceived patterns for the way things "ought to be," and not necessarily in reference to the client but how they "ought to be" for the crisis worker (Freudenberger, 1977).

The general axiom of psychoanalytic therapy is that countertransference needs to be guarded against, and the therapist's refusal to recognize it and deal with it can, at the least, inhibit the therapist's effectiveness, and at the most, be destructive to the relationship (Dahlenberg, 2000, pp. 1–6). If the phenomenon of countertransference is not recognized and dealt with in positive ways, the human services worker ends up feeling guilty about having negative feelings toward the client and is not even sure why those feelings are occurring. Such feelings are antithetical to what the worker has been taught and believes and can significantly compound the occupational stresses that lead to burnout.

However, Pearlman and Saakvitne (1995a, pp. 22–24) propose that if crisis workers are to deal successfully and understand the pain of their clients in deeply empathic ways, then countertransference is inevitable and necessary. Particularly emotion-laden issues such as physical and sexual abuse of children, terminal illnesses, and chronic suicidal ideation are prime examples of content that may be exceedingly

stressful to the worker because of strong feelings and experiences the worker may have about the problem (Dahlenberg, 2000; Fox & Cooper, 1998; Pearlman & Saakvitne, 1995a). The pluses and minuses of countertransference as it applies to trauma appear to balance precariously on a very thin psychological high wire. Main's (2008) study of sexual offender treatment providers found that while they manifested disruptions in cognitions, emotions, and behaviors consistent with those that characterize compassion fatigue and vicarious traumatization, they also possessed many of the components for **compassion satisfaction** (the positive feelings and intrinsic rewards one feels from helping others who have experienced a traumatic event) (Stamm, 2010) and reported that their child sexual abuse histories were an advantage in the treatment of sex offenders. As such, one of the critical components to handling countertransference effectively would appear to be close and competent supervision.

Secondary Traumatic Stress/Vicarious Traumatization/Compassion Fatigue

STS/VT and CF are different from the phenomenon of countertransference. As these terms have evolved, they have taken on somewhat different, more discrete meanings. **Secondary traumatic stress/vicarious traumatization** is the transformation that occurs when an individual begins to change in a manner that mimics a client's trauma-related symptoms. It is a constructivist model in which the individual's experience and worldview are changed as a direct result of secondary exposure to trauma through crisis work (Pearlman & Mac Ian, 1995). As an example, in a study conducted by Alexander and associates (1989), researchers who were deeply involved in reading and reviewing rape cases and not actually talking to the victims started to manifest victim pathology. The bottom line is that all of these terms apply to a worker who has been affected by long-term, intense involvement of some type with very traumatized clients.

STS/VT and CF occur as a result of an accumulation of experiences across therapies and clients and are felt far beyond the transference–countertransference issues of a specific client–therapist relationship. Whereas countertransference is temporary, STS/VT and CF have the potential to permanently change the psychological constructs of workers who engage in intense and long-term trauma and are an inevitable occupational hazard of trauma work (Saakvitne & Pearlman, 1996, p. 31). In summary, a worker who has a full-blown case of STS/VT doesn't look and act very much different than the PTSD clients they are treating.

The end result of VT and CF is their generalizing effects on countertransference issues. As VT is multiplied and generalized over clients, countertransference reactions become stronger through the human services worker acting them out against the client or submerging them even deeper from awareness (Saakvitne & Pearlman, 1996, p. 48). For human services workers in general, and crisis workers in particular, VT/STS and CF are major mediating factors that lead to burnout. In fact, Cieslak and associates (2014) conducted a meta-analysis that examined the relationship between STS/VT and burnout and found a substantial overlap between the two particularly if measured in the framework of compassion fatigue.

Worker Vulnerability. Maslach (1982b, pp. 36–37) states that the only human services workers who burn out are the ones who are on fire. For such workers, Saakvitne and Pearlman (1996, pp. 26, 49) and Figley (1995) believe that the deep empathy needed to deal with the heart-wrenching situations that often accompany crises makes workers vulnerable to intense and overwhelming feelings and profound disruptions in their beliefs, and assaults the very core of their hope and idealism. Over time, such assaults lead to compassion fatigue (Figley, 1995), wherein the crisis workers' energy is literally wrung out by the incidence and amplitude of dealing with the horrific problems that trauma clients face.

Between a very real dedicatory ethic and at times an insatiable need to assist everyone with any type of problem, the idealistic human services worker sees his or her job as a calling. In an imperfect world, such an idealistic outlook can lead to over involvement and identification with the client—often to the worker's detriment (Koeske & Kelly, 1995). As the human services worker becomes more deeply enmeshed in the helping relationship, the worker's strong need to be accepted and liked makes it harder and harder to say no to the client's demands. At this point, the worker has started to take on responsibility for the client.

The worker's over involvement with the client may be manifested in a variety of ways. Some of the many indicators that the worker is not paying attention to his or her own needs, or frankly to the client's, include extending the session beyond its usual time limit, taking and responding to phone calls at home at all hours of the night, experiencing hurt feelings

over client failures, attempting dramatic cures on impossible cases, becoming panic stricken when well-laid plans go awry, refusing to withdraw from the case when it is clearly beyond the worker's purview, becoming angry, sarcastic, or bored with clients, changing the subject and avoiding the topic, providing pat answers, discounting the client's problems and minimizing distress, not believing clients, fearing what the client will say, silencing client trauma talk, wishing or suggesting the client would "just get over it," feeling numb or avoidant, not being able to pay attention, being constantly reminded of one's own personal trauma events, hoping the client won't show up, becoming frustrated over lack of progress, and losing one's sense of humor over the human dilemma (Baranowsky, 2002; Dahlenberg, 2000; Van Auken, 1979). The foregoing are all indicators that unresolved countertransference and vicarious trauma/compassion fatigue issues are flourishing.

Under these circumstances, the worker comes to see the helping relationship as a chore, and the client may regress and act out as a way of announcing the client's awareness of the worker's apathetic attitude. As this psychological vortex continues to swirl and the worker becomes even more overwrought and discouraged, the client is likely to terminate the therapeutic relationship (Dahlenberg, 2000; Watkins, 1983). Such negative reinforcement does little to mollify the worker's already bruised ego and may lead to a further downward spiral into burnout. Whether exposure to these occupational hazards has negative or positive outcomes depends a great deal on how both the individual worker and the human services institution deal with them in proactive ways (Dahlenberg, 2000; Deiter & Pearlman, 1998; Figley, 1995; Pearlman & Saakvitne, 1995a; Saakvitne & Pearlman, 1996).

Intervention Strategies

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While there is a great deal of literature on self-care and balancing other life experiences against work as a buffer against burnout (Ling et al., 2014; Oerlemans & Bakker, 2014), there have been few protocol and hard data studies to identify specific treatments that work with those who are experiencing STS and are burned out (Bercier & Maynard, 2015).

Practitioners on the road to burnout typically are perfectionistic workaholics (Falco et al., 2014) who push relentlessly toward emotional exhaustion, becoming more inefficient and unhappy as they do so. Note the "aholic" component because our experience is that burning up professionals are much the same as alcoholics in their vehement denial that things are going badly awry until a severe crisis of their own is created such that it finally gets their attention. Thus, when we consider individual crisis intervention with an impaired fellow professional, emphasis in applying the crisis task model in this book will usually focus on the directive end of the continuum because of the depth of the crisis and an "I know more than you do, and I'm not nuts" fellow worker. The crisis interventionist who helps a burned-out human services worker typically must proceed in a very directive manner while confronting the client's irrational beliefs, proposing definite alternatives, and getting the client to commit to specific action steps that will get the person out of the state of immobility. Put in simple terms, fellow human services workers are some of the most stubborn and denial-prone clients there are when they have reached the later stages of burnout.

Intervention for the human services worker suffering from burnout may best be considered in three distinct dimensions: intervention through training, intervention with the organization, and intervention with the individual. Triage assessment of the level of burnout is important in determining the type of intervention to be used. At a trait level, individual therapeutic intervention will clearly be warranted. At a state or activity level, training or organizational intervention may be sufficient. When the organization itself becomes a client, triage assessment would

clearly include the administering of both burnout and work-setting instruments to all members of the organization and following up that administration with individual interviews.