CHAPTER 10

Transference and Countertransference in Complex Trauma Treatment

In this final chapter, we address in more detail how psychic and interpersonal dynamics associated with victimization and resultant reactions additionally affect the treatment relationship and what therapists can do to handle these issues effectively. We describe how complex trauma can be reenacted in the transference and countertransference and how therapists can be drawn into a number of common trauma-related countertransference positions and roles that are complementary to their clients' transference reactions. We use the concept of projective identification to describe how therapists can understand and respond to posttraumatic enactments using their own (emotional and somatic) feeling states as guides. None of these reactions and processes is "bad" or problematic per se but rather serve as useful (albeit implicit and thus coded) information that may be the client's best way of communicating. In the final section, we describe various role enactments engaged in by therapist and client that are common in the treatment of complex trauma and offer ways to understand and to use them productively.

The therapist's attitude, as well as his or her own history of attachment and other forms of trauma and the degree to which they have been resolved, play a major role in the ability to successfully treat complex trauma. Although societal attitudes are slowly shifting with increased knowledge and recognition, they unfortunately remain largely disparaging and negative. Therapists are subject to the same stereotypes and biases and are thus influenced by the cultural surround and organizational culture in addition to their more personal reactions. Other challenges arise when therapists are castigated by peers for having empathy for and treating these clients (especially those who carry a borderline personality diagnosis or who are highly dissociative). Simultaneously and in apparent contradiction to this disparagement, they may find that all cases of trauma in their agency or community are assigned to them, a practice that can result in their becoming overloaded, exhausted, resentful, and angry (in addition to being vicariously traumatized by their clients' stories and their peers' behaviors). Identifying trauma-informed colleagues for consultation and emotional support is especially important in such a circumstance, as is the move toward trauma-informed services (Bloom & Farragher, 2010; Harris & Fallot, 2001).

TRANSFERENCE THEMES, ISSUES, AND REACTIONS

Gartner (1999) offered this succinct definition: "Transference . . . refers to all feelings and reactions to the therapist, conscious and unconscious, enacted or not, reality- or fantasy-based, that originate in and are located in the patient" (p. 234; italics added). Concerning transference and attachment styles, Brisch (2002) added: "Bowlby proceeded from the assumption that early-childhood representation of self and parents with their corresponding attachment and exploratory strategies are reactivated in the transference" (p. 79); this is a stance found in object relations theory as well (Fonagy et al., 2002). Transference issues are seen as arising from personal reactions of the individual that originate in his or her formative relational experiences with caretakers that have been internalized. Although clients with complex trauma are aware of many feelings and issues in their current lives, the fact that these feelings and associated beliefs are "transferred" from relational dilemmas that occurred implicitly earlier in life is largely outside of their awareness. It is usually obvious to therapists that something more is troubling these clients than can be accounted for by current life circumstances and relationships. So part of the therapeutic challenge is determining what is being "transferred" and how best to help clients recognize what is disconnected. When complex trauma is in the picture, this challenge includes determining how to help clients to distinguish trauma-infused beliefs and body and emotion states from the beliefs and feelings they experience when not in a posttraumatic or dissociative condition. This then involves the process of identifying and modifying their ways of thinking and feeling about themselves, other people, and the world through the use of cognitive-behavioral and affect-based therapeutic strategies, their physical and visceral sensations through experiential and sensorimotor therapies, and their relationships through interpersonal approaches to individual treatment and group, couple, and family modalities.

Just as transference reactions may be the best way the client can cope with and implicitly communicate about extremely threatening and
distressing past experiences and current states of body and mind, countertransference responses may be the therapist’s best way of understanding the client’s dilemmas and countercommunicating. “Counter” transference, as the name implies, is the therapist’s own transference reactions to those of the client. If unrecognized and unexamined, countertransference can lead to nontherapeutic or even harmful iatrogenic actions by therapists based on their own emotional biases, conflicts, or attachment or trauma history (Greenon, 1967). The problem of hurtful or even harmful countertransference-based actions by therapists is even more acute when clients’ transference involves intense posttraumatic distress, such as feelings of rage, disgust, or hate (Winnicott, 1963). However, when therapists take steps to be aware of their countertransference issues and to regulate the strong emotional reactions that accompany their activation, these can be invaluable sources of information and lead them to an empathy with and understanding of their clients.

**Traumatic Transference**

According to Spiegel (1986), traumatic transference occurs when “the patient unconsciously expects that the therapist, despite overt helpfulness and concern, will covertly exploit the patient for his or her own narcissistic gratification” (p. 72) in much the same way parent(s) or other abusers did. Per Chefetz (1997), traumatic transference “is a given in the therapeutic situation of persons with post-traumatic disorders” (p. 259). Through this transference, the traumatized client communicates his or her fears and expectations of being revictimized and used by the therapist in some way. This is a difficult transference for therapists to accept and to tolerate. Another aspect of traumatic transference has to do with the treatment process itself. Although intended to provide help and relief, it might be experienced instead as abuse or pain that is being deliberately inflicted by the uncaring and even sadistic therapist. This, too, may elicit strong response in the therapist, whose objective is to provide help. Treatment must be undertaken with due consideration for the significance of issues such as these. They should not be minimized or dismissed but rather should be used to elicit more about the client’s past experiences that would result in such negative expectations of others. A major challenge is for the therapist to understand how the treatment context and his or her role (as a stand-in for parents and other authority figures who were absent or abusive) might feel dangerous and hostile while he or she is concurrently working to create a safe enough environment for the material to come forward for identification and discussion.

Hypervigilance in relationships with others (including the therapist) is therefore to be expected, as these clients characteristically are on the lookout for ways that someone might take advantage of them. Chefetz (1997) noted how this can result in the therapist getting caught in the countertransference trap of proving him- or herself “better than” abusive and neglectful others and, in the process, avoiding negative emotions. It behooves the therapist to acknowledge base emotions and motives, the “shadow” (Kopp, 1980) and the related potential of all humans to have these emotions and to be exploitive and abusive. It is ironic but understandable that when therapists are able to accept and acknowledge such feelings, clients may experience them as more real and therefore more trustworthy. Therapists are also less prone to act on their feelings when they have identified and even embraced them.

Traumatic transference reactions may emerge in indirect or paradoxical ways. The client with complex trauma who seems only to have a positive transference and who idealizes the therapist as “the best” may be superficially compliant, eager to please and not alienate the therapist. This may, however, be a disguised traumatic transference in which the therapist is reacted to as a perpetrator who must be catered to, excused, and protected in order to avoid eliciting a wrathful reprisal if normal feelings of disappointment, fear, hurt, or anger are felt and (indirectly or directly) expressed. Defenses such as denial, repression, or reaction formation may be employed to avoid recognizing previously forbidden negative feelings. The therapist who can appropriately (i.e., without any direct or indirect blame, criticism, or retaliation) acknowledge negative or other thorny feelings as they emerge in the transference and countertransference and who communicates to the client that any and all feelings are acceptable and expectable provides a valuable model and a responsive context. As noted in the previous chapter, learning that individuals can be angry (or can have any other emotion) with one another and remain in a relationship is often eye-opening and growth-producing for survivor clients. It is a clear counter to the relational lessons from insecure/disorganized and otherwise abusive backgrounds in which disparagement, invalidation, and emotional and relational cutoffs were the norm rather than respect, encouragement, and discussion, resolution, and repair.

In a similar vein, the therapist should expect to be drawn into posttraumatic and related abandonment and rejection reenactments. For example, as noted at different points throughout this book, clients who were taken advantage of when an offender used a relationship against them (the process of “attack-ment” described by Chefetz, n.d.) may experience the therapist’s empathy as dangerous rather than comforting. Quite ironically, it is at the moment of increased attachment and vulnerability that the relationship is most fraught with associations of abuse, causing clients to self-protectively disengage, a process that may be so automatic as to be outside of conscious awareness. At these points in therapy, the most accurately empathic communication by a therapist is a frank acknowledgment that the client’s past experiences understandably have made kindness or compassion seem to be dangerous or deceptive. This can be followed by a clarification that one goal of treatment is to understand these reactions and their origin and another is to assist the client in developing knowledge and skills to make fully informed choices about whom to trust. The client’s reactions are not
perceived as threats to the therapy, a personal affront to the therapist, or a source of conflict between them, but as a first step in learning to differentiate safe, reliable, and trustworthy others from those who are not.

Detachment and withdrawal through emotional shutdown and through other interruptions, such as missing appointments and nonpayment of fees, might signal the client's self-protection in the face of perceived danger rather than noncompliance and hostility (although these, too, are possible responses). The therapist must have sufficient maturity and emotional resources to experience these disruptions and their associated negative transference reactions with some degree of composure and not make assumptions about them before bringing them to the client's attention for discussion and for the reestablishment of boundaries. This approach usually helps the therapist in not taking reactions personally or in retaliating in response.

In yet another difficult relational transfer, the surfacing and discussion of painful emotional material might cause the client to suspect that the therapist's interest is feigned and that, in fact, he or she is gratified by causing the client emotional pain. The identification of this type of transference must be made with sensitivity to its origin and again without the therapist taking it personally or striking back. Rather, the therapist is again called on to be self-possessed and to demonstrate to the client (often repeatedly), through his or her actions and reactions, empathic attunement to the pain rather than gratification in causing it. Thus the therapist walks a fine line in needing to approach traumatic or otherwise emotionally painful material (in some detail and not colluding in its avoidance) while respecting the emotional toll the process takes on the client. This calls for sensitivity to the range of the client's emotional capacities and pacing of the treatment.

Erotic Transference

Transference love (or friendly or affectionate feelings toward the therapist) was initially regarded as positive and can be seen as a precursor concept to erotic transference. Erotic as used here connotes desire and the need to be special rather than its sexual counterpart (although it can certainly be sexualized). Clients with complex trauma understandably long for something most did not have: to be seen as special and to be treated in kind. Quoting Cheferz (1997): "The erotic transference may be experienced as an intense, relentless demand to change the therapeutic relationship in response to the patient's special need" (p. 256). It manifests when the therapist feels "coaxed, enticed, lured, tempted, attracted, persuaded, charmed, corrupted or fascinated" (p. 256) by the client, resulting in shifts in the treatment frame in order to meet the client's longings and needs. It may only be identified once the therapist "comes to" and realizes that this client is being treated differently from others, sometimes after boundaries have been crossed and/or after identification in consultation or supervision. Gradual identification and verbalization of the client's need may be very helpful for the client, who can then own it and its legitimacy and resultant feelings (often grief and loss at not having been treated as special or with respect), while the therapist pulls back into the established treatment frame. It is not the therapist's job to make up past losses but to help the client own and grieve them (Calof, 1987; Courtois, 1988, 2010).

When the transference is eroticized in the form of more direct sexual intention and behavior by the client, this sexualization may be a reenactment of sexual abuse or it may be an extension of the longing to be loved, prized, and admired as special, to give the therapist a unique gift of self, or to be in a special relationship. Conversely, a sexualized transference may have less to do with love and affection than with power and dominance as a manifestation of the client's history of relationships with caregivers or authority figures in which sexual activity and involvement played a prominent role. Thus, being dominated by the therapist and being in a dual sexual relationship might be expected as the price of attention or because it is an acceptable aspect of any relationship. Sexualized transference may be a way for the client to induce the therapist to view him or her unconditionally available and/or as defined or degraded. Attempts at sexualization may be the best way to test the therapist's trustworthiness and integrity, as we discuss next. The universal proscription against therapists reciprocating any sexual advances by a client or initiating such advances is a crucial boundary protecting the client from betrayal and violation.

Betrayal, Disillusionment, and Mistrust

Interpersonal betrayal and exploitation in the most significant attachment relationships adversely influences the ability to trust and creates enormous disillusionment in complex trauma survivors. It is for these reasons that the therapist can never take trust for granted, even that of the idealizing, dependent/preoccupied, or compliant client who professes unconditional trust or even after therapy has been ongoing for a period of time and a high degree of trust has developed. In order to be appropriately vigilant about trust, the therapist should be especially attentive to any aspect of the therapy that raises questions about his or her intentions and integrity and should make every attempt to be emotionally transparent in the moment and scrupulously honest.

Throughout the course of therapy, the client may consciously or unconsciously test the therapist in attempts to reinforce the belief that no one really cares or is truly trustworthy. While simultaneously craving it, the typical client with complex trauma fears the therapist's caring due to his or her predominantly negative self-perceptions and fears increased vulnerability to possible judgment and criticism, ultimately leading to abandonment, rejection, and reprisal. Such a relational trajectory may be seen as inevitable to the client who fears being seen as the client judges him or herself as rotten at the core and then as secrets related to the past are disclosed. Clients who have been repeatedly subjected to double-bind communication tend to
place therapists in double binds that replicate those from their own troubled childhoods. Having had to defend themselves psychically against betrayal and abandonment from an early age, these clients are acutely perceptive about other people's points of psychic weakness, conflict, or pain. Thus, in their own repetition of “attack-ment” (Chegoff, n.d.), it is not uncommon for them to “zero in” on their therapist's most vulnerable personal issues when testing his or her ability to maintain integrity in the face of either opportunities to be seduced or exploited (e.g., when a client makes provocative erotic overtures or direct sexual invitations) or assaults on personal and professional integrity, competence, and worth (e.g., interrogations by a client regarding the therapist's financial or ethical practices). Therapists, for their part, must do their best not to personalize this testing, even when it includes virulently and apparently irrational ad hominem accusations. Although the emotional turmoil engendered by these types of “tests” can challenge any therapist's poise and focus, the transference can be used to better understand the client's schemas about self and others.

As the therapy progresses and the client delves more deeply into salient relational issues or as crises develop inside or outside of therapy, transactional testing and resultant crises in trust should be expected to intensify or resurface. Crises, by definition, are times when the need for proximity to the caregiver or attachment figure is greatest. Anxiety develops concerning abandonment and being let down, which would replicate past experience. A crisis can provide the therapist with a singular opportunity to demonstrate trustworthiness by remaining responsive, available, and consistent. This presents the client with a relational experience opposite from what has been previously experienced and therefore expected. This has great potential to challenge and disrupt ongoing relational assumptions and schemas and to replace them with new ones.

An even greater trust problem for clients with complex trauma is trusting themselves, their own perceptions and reality, behaving in ways that are trustworthy and then believing that they are trustworthy. They often live with the expectation that others will hold them in the same contempt in which they hold themselves and, as a result, will treat them poorly and with disregard. Feeling undeserving of positive attention, they fear that sooner or later the therapist will discover their essential badness. They further expect a reenactment of any nonprotection, blame, or disparagement they previously experienced. Because of who they are, they fear that the therapist will shun and castigate them.

The disconfirmation of self and the restructuring of reality that are hallmarks of interpersonal trauma are reflected in the therapy, with the client constantly second-guessing his or her memories and emotions, all the while questioning personal sanity. The therapist's task is to assist in re-contextualizing these profound self-doubts and self-accusations in light of the exploitation, abandonment, coercion, and losses of the past. This approach supports the client by helping her or him to recognize that the intensity of current distress is understandable as a posttraumatic reaction or adaptation, in the process encouraging the identification and development of the client's self through the expression and reintegration of what was previously split off and through direct emotional support.

Interpersonal and Intimacy Difficulties

Difficulties developing satisfactory and nurturing relationships can be a lifelong issue. Some clients (especially those with a detached/dismissive style) defend against the possibility of any more hurt or betrayal by cutting themselves off through hypooattachment. Their attitude may be expressed as “nobody/thing will hurt me because I'm not going to put myself in the position of allowing anyone in. I can take care of myself. I'm fine, I don't need anybody.” These self-sufficient individuals are typically isolated and withdrawn and might be indifferent to others or aggressive and averse in their interactions. It may be difficult, if not impossible, for them to accept positive regard when it is forthcoming from anyone, much less the therapist. These clients may do everything in their power to sabotage the feedback or relationship, reverse it, or flee from it. The therapist must maintain an awareness of engaging with a relationally injured and betrayed individual who is fearful (and even terrified) of engagement with anyone, especially an authority figure (and much less in a confined private setting in which self-disclosure is expected to occur) and must gradually encourage engagement without reinforcing fear of the disengagement/flight response.

To manage the anxiety of waiting for the “bad” to happen, some clients make it happen by engaging in self-defeating behavior, behaving aggressively, or otherwise manipulating the situation to bring about the expected response: “If it's going to happen anyway, I might as well make it happen so that I'm in control and I get it over with”; “If I'm going to be left anyway, I'll leave first; that way, I'll have control and it won't hurt as much.” Self-sabotage can occur in many areas of life, in relationships with family members and friends, in school or work settings, as a way of defending against the anxiety associated with doing well or as a contradictory means of maintaining control and thereby maintaining safety. Even when they are obviously successful, these clients tend to disavow their own accomplishments and abilities and describe themselves as imposters. Furthermore, they discount the positive and seek ways (often unconsciously) to reverse it. Due to ingrained negative self-beliefs or the fear of being seen as selfish, the client may additionally disallow or renounce any needs or desires and respond to compliments and other positive feedback with anxiety, guilt, and consternation. He or she may diminish or externalize credit for all accomplishments in order not to draw attention from others (another way not to be selfish).

Another complication is that many of these clients have learned to present a false self (ANF) to the world as a means of avoiding distressing
emotions and memories (EP). The client may appear to be engaged in the treatment when, in fact, he or she is only working on surface issues without internalizing them or actually making changes. Dissociative clients, in particular, describe not being able to remember what was said from session to session, keeping information out of awareness as a way of protecting themselves, and rejecting the possibility that they can establish and maintain personal control. In such cases, it is important for the therapist to serve as an “auxiliary ego” and “memory trace” early in treatment, to assist the client in activating her or his own working memory and long-term memory retrieval capacities, which have been taken “off line” by dissociation and avoidance. This does not mean encouraging clients to try to remember traumatic or other formative events from earlier in life in order to “restore” their memories or to regain “lost” or “repressed” memories. It is not the content of memories that is the issue, but instead the ability to retrieve and retain pertinent autobiographical information in order to become “known” to the self and more cohesive. Retrieving distant memories becomes increasingly possible as the client is able to engage in here-and-now memory processes that support increased self-awareness.

An opposite style is evident in some clients who inflate their abilities and sense of self with exaggerated competence, entitlement, and grandiosity to counter their feelings of depression, powerlessness, and “badness.” Some may express anger and bitterness that their skills and talents have not been recognized or nurtured and may even use this fact to rationalize any lack of success or ability to achieve personal goals. A narcissistically inflated sense of self further defends against fear associated with being put to the test and developing relationships with others, as a type of self-fulfilling prophecy. Grandiosity and entitlement can be used to set the self apart in a superior way that alienates or intimidates others, including the therapist, in the interest of reinforcing a sense of being different, usually with the unintended effect of intensifying loneliness and isolation.

Interaction patterns such as these make clients needy of affection, nurturance, and attention, hungry for emotional resources that are viewed as available only from outside. The therapist is challenged with a client who does not trust or feel deserving of a good relationship and who unconsciously sabotages one as it develops and yet needs (and paradoxically actually expects to receive) exactly the nurturance that is most feared. Additionally, the intensity and sometimes the instability of the client’s engagement can provoke strong counterreactions. The client is faced with a painful dilemma, one that the therapist must work at understanding and empathically reflect back. In order to recover from the traumatic psychic injury, the client must tolerate and allow the development of a reparative human relationship. Complicating the dynamic further is that many clients are exquisitely attuned to the reactions and feelings of others. Some describe themselves as radars and chameleons, constantly scanning for problems and changing behavior to accommodate the needs of others or to escape perceived danger and interpersonal conflict. Minor mood or behavioral changes in others are registered, often unconsciously, resulting in an instantaneous shift in response. Moreover, changes in others (which in reality may have nothing to do with the client) may be personalized or misattributed. With honest feedback from the therapist about his or her reactions and responses, the client has the opportunity to become aware of biased perceptions and appraisals and to change them.

Guilt, Complicity, and Responsibility

Many clients do not realize the extent to which they make themselves the guilty one, usually the only guilty one, and confound their guilt with their very identity and existence. They may continuously apologize for themselves and take a deferential stance with others, including the therapist. Many blame themselves for not having been able to say no or otherwise not having prevented their mistreatment or that of others. Their guilt also results from having been blamed and made a scapegoat from the internalization of what they were told. Guilt may be the cover emotion that masks other associated emotions, such as sadness, shame, anger, and grief. Finally, they might be carrying guilt for what they did, as well as what they did not do, and for how they coped, especially with such issues as substance abuse, self-harm, harm of others, and suicidal gestures and attempts.

The survivor client may feel a combination of love (trauma bonding), unrequited loyalty, and hate toward the abuser(s) or involved others and may fear losing the good parts of the relationship if responsibility for abuse is directed at the guilty party. A client’s protectiveness of the perpetrator may also be due to role reversal or “parentification,” coupled with an overdeveloped sense of responsibility and misguided loyalty. The client may experience anxiety and a sense of being disloyal when giving up the role of “protector of the family or community of its secrets.” In discussing these issues, the therapist must not blame or blame the abuser or others even while not condoning abusive behavior, remaining mindful of the strength of trauma bonding and the pull of ambivalent attachment and loyalty (even when undeserved and unrequited).

Secondary Secrets

A particular transference may be most related to sexual victimization. Further confusion about feelings of guilt and responsibility develop in the child or adolescent who experienced sexual pleasure, personal power, or other reactions as part of the abuse and/or who sought revenge or to hurt others by seeking out contact and “willingly” engaging in the abuse with perpetrators or by perpetrating against others. These issues are the secondary secrets or “secrets within the trauma secret” (Courtois, 1986, 2010) that can have a very powerful hold. By virtue of strong feelings of shame
associated with them, they might only be disclosed late in treatment. Their identification is essential in order both to lift the “veil of secrecy” that can stalemate therapeutic progress and to empower the client to reconsider beliefs about her- or himself that have been locked in by the combination of abuse and keeping secrets. When these issues finally emerge, clients may spontaneously disclose that these were their most closely shielded feelings and issues. Their exposure and resolution are therefore exquisitely sensitive.

Issues of Sexual Pleasure and Other Sexual Responses
Some abusers take great pleasure in the victim's sexual response, orgasm, and ejaculation. These may be used to support the rationalization that the victim enjoyed the abuse and as a means of coercion by inducing self-doubt, self-blame, or confusion. As a result, sexually abused clients may bring into the therapeutic relationship the belief that they must use sexuality as a way of gratifying or acquiescing to the needs of caregivers. Alternatively, they may believe that sexual behavior can or should be used to achieve power in relationships. They may interact in a sexualized manner in therapy as a conscious or unconscious abuse reenactment intended to reduce their emotional vulnerability.

The therapist who is unaware of this possibility or insensitive to its meaning may make the mistake of interpreting sexualization as seduction and attempt to deal with it simply by insisting that the client dress or act “more appropriately.” Yet, the psychic and relational dilemma(s) that led the client to behave in a sexualized way should be the therapeutic focus. Just as it is essential for the therapist to insist on appropriate behavior on the part of the client, so too must he or she be scrupulous in maintaining appropriate therapeutic boundaries and roles. Judith Herman (1992b) counseled therapists to “respectfully refuse the client's invitation to become another sadistic abuser.” The responsibility for proper boundary management rests entirely with the therapist, who has the ethical and professional duty to not exploit the client in any way, to protect the client's welfare, and to help him or her to develop the capacity and confidence to do so by recognizing traumatic reenactments. A protective, nonexploitive, and awareness-enhancing therapeutic environment is imperative for the client to experience how it is possible to be in a relationship not based on sexual interaction, sexual favors, or coercion. This foundation provides a basis for the client to recognize and choose intimate personal relationships in which feelings of sexual attraction and longing can be explored and safely experienced.

Hyperresilience and Parentified Caretaking
Some clients appear to be virtually invulnerable (i.e., superman or superwoman) and to be all things to all people, while juggling multiple roles and responsibilities and continuing to be self-effacing and deferential. Through hyperattribution to the needs of others, they care for and protect others, less functional or more vulnerable people. The outward indomitability tends to be an authentic (and admirable) positive quality rather than simply a facade, yet these individuals often tend to harbor (and fear acknowledging) deep feelings of guilt, shame, and inadequacy despite their, at times, remarkable ability to overcome many kinds of adversity. They often drastically underestimated their actual ability to maintain control, coming to view their abilities and personal worth either as a burden that they are fated to bear or as a sham and a mere defense against an ever-present and inevitable descent back into the chaos experienced earlier in their lives. Their caretaking may mask other and less positive feelings (such as rage and hostility), keep feelings of depression at bay, or may be due to their close identification with the underdog and the desire to provide others with better than they received. What they did not receive may make them exquisitely attuned to the needs of others.

Selfless (or self-sacrificing) caretaking of others can likewise serve as an overlearned way to manage and limit intimacy by preventing anyone from getting close. It is fairly typical for these clients to become involved with dependent, immature individuals who want someone to take care of them (at one end of the spectrum) or those who are cold, indifferent, dismissive, and/or abusive and who take much but give little in return (at the other). Whatever the style, reciprocity is lacking, and clients' needs are neither acknowledged nor met (by themselves as well as by others). These clients may seek help only when totally overwhelmed and desperate, usually when faced with multiple crises. They tend to be embarrassed and ashamed when seeking treatment because they feel they have failed. Indeed, seeking help puts them in an unaccustomed and even terrifying position that they interpret as meaning that “everything is falling apart” or “my true incompetence or worthlessness has finally been exposed.”

It is left for the therapist to suggest a middle ground between these diametrically opposite views of self (i.e., as invincible and irreproachable vs. as powerless and reprehensible) and others. The therapist must take care not to be lulled by the client's presentation of being high functioning, pleasant, acquiescent, and caring at all times. Although these attributes are real and should not be dismissed as mere cover-ups or manipulations, they nevertheless do cover up emotions, beliefs, and tendencies that might be frightening, disorganizing, and appalling to the client. He or she can be extremely charming and convincing in manipulating others to overlook personal foibles and instead to be experienced as “all good.” The cost to the client of using these real personal strengths to cover up doubts, fear, hurt, anger, and shame is a critical therapeutic focus. However, because therapy in this sense is akin to a public unmasking of the Wizard of Oz, it is important to help clients gradually recognize and accept their troubling feelings, thoughts, and impulses as real but manageable and not as a
complete undoing of their self-worth or their overly positive persona. This is another reworking of the ANP (Van der Hart et al., 2006) in which the client's posttraumatic adaptation is recognized but is also dismantled in a way that allows him or her to control actions and interactions rather than to continue being compulsively driven by avoidance.

Another example of this transference pattern occurs when the client (usually one who is insecure or preoccupied) idealizes the therapist as the all-good and all-knowing authority figure. The therapist is put on a pedestal and treated with "kid gloves" and with undue deference. The client feels unworthy of attention, caring, or help from a person as exalted as the therapist and believes that the therapist's needs must be given priority with little or no regard to what the client might really feel or need. Although it can be helpful for a client to see the therapist as a role model, healthy feelings on the negative end of the spectrum and negative transference reactions that are problematic but important to address in therapy might go unrecognized and unexpressed by the client who believes that having or expressing such feelings threatens the relationship. In a contradictory fashion, beliefs such as these may be maintained by a client's implicit view of the therapist as too fickle, selfish, or withholding to tolerate the client's expression of her or his own feelings, thoughts, or needs, all the while treating the therapist as all powerful and potentially rejecting. In a variant of this presentation, clients may be frankly dismissive of the therapist and therapy, denying having any needs or perceiving the therapist as inadequate to meet them. Through such counterdependence the client devalues the therapist as a means of avoiding or defending against becoming aware of his or her fear of rejection and betrayal by anyone who is entrusted with his or her well-being.

In order to address these idealizing or devaluing transferences, the therapist must help the client to recognize and express feelings and perceptions that are based on legitimate grievances associated with his or her relational slips and missteps (i.e., the "empathic failures" that are committed by every therapist, no matter how experienced or skilled; Kohut & Wolf, 1978). Equally important, the client must be helped to safely acknowledge and express feelings based on a variety of real and perceived personality traits, professional status, and other life advantages attributed to the therapist. When the overidealization can be dismantled without harm or retaliation, it demonstrates that emotional expression is not only allowed but actually enhances the security and responsiveness of healthy relationships. This is in direct contradiction to the rigidity and punitive orientation that characterize unstable and one-sided abusive relationships.

Anger, Rage, and Outrage

Many clients with complex trauma are adept at disowning their feelings of anger, displacing and expressing them in disguised forms (e.g., through passive-aggressive behavior, manipulation, somatic complaints, self-blame, and self-injurious and suicidal behavior). The suppression or misdirection of these feelings is primarily due to fears of their explosive and uncontrolled discharge and inexperience with more modulated means of expression. The enraged client can be frightening for the therapist, who might self-protectorily distance. If danger is not imminent, a more therapeutic strategy is first to accept and legitimize the anger (often this type of response is "settling" to the client, who experiences relief at having it recognized and at not being stigmatized or chastised) and then to assist in establishing boundaries, regaining control, and finding modulated means of expression and discharge. The application of skills for self-regulation supports the toleration and management of emotions without their being indiscriminately discharged against self or others (including the therapist).

(See works on anger management in Self-Help Resources and Workbooks [in the online supplement to this book].)

Loss and Grief

As discussed previously, the client grieves for past and present losses, fears of losing significant relationships, including with the therapist, can intensify. Unfortunately, some of these fears may come true. As clients become healthier, stronger, and more assertive, they may become more autonomous or detached from abusive or neglectful others who, in response to being threatened by the changes, want them to "change back." Sadly, personal growth might come at the expense of long-term relationships that end up faltering or ending. Reliance on the therapist and supportive others may be particularly needed during these relational losses and transitions.

Within the therapy, separations for any reason (e.g., professional conferences, vacations, holidays, illness, childbirth, emergency, or crisis) or the impending end of treatment should be announced and prepared for well in advance whenever possible. Many clients need repeated encouragement to identify and express feelings about therapist unavailability, whatever the reason, to counter the tendency to be overly understanding and disowning of any negative feelings or neediness. If and when these feelings do surface, they might be dismissed by the client as childlike and uncalled for (e.g., "I feel like a crybaby when I feel like this and I can't stand it! I'm just being ridiculous to let myself be upset that you will be away"). The client clearly needs support and validation for whatever emotions emerge, especially anger and fear, which are so easily denied or displaced. In the event that the client holds faulty assumptions and misattributions about separations, if it seems appropriate, the therapist might be factual about the reasons for an absence ("All of us need to take breaks and vacations; I find they help me maintain the energy and focus I need to do this work") and sharing his or her emotions about the separation ("I will miss you and our time together"); "I will not forget you while I am gone, nor will you forget me; we'll keep each other in our minds"); "I hope you can use me as a model to allow
yourself to take some time off"). Clients frequently benefit from knowing
that the therapist’s absence does not mean a cessation of caring, disregard,
or forgetting or an abandonment (although it might feel like one), nor is it
due to personal dislike or hostility.

Clients’ fears are sometimes reflected in extreme concern for the ther-
apist’s safety during a separation. They might be highly superstitious that
something bad will befall him or her as punishment. An accident or mishap
would conclusively “prove” the client’s malignant power and repeat the
losses experienced in other significant relationships. Exploration and expo-
sure of the faulty beliefs are warranted. The therapist can offer reassurance
about intending to return and can further note that if something beyond his
or her control was to happen, it would not be the client’s fault, nor would
it be personal punishment. The therapist should not make promises that
are unrealistic, cannot be guaranteed, and are not under personal control
(e.g., “I promise I will never leave you; I will always be available to you, no
matter what.” “Don’t worry, nothing bad will happen to me.”).

In keeping with the philosophy of individualized treatment, individu-
alized plans for separations might be required. Yet the therapist must steer
clear of overly solicitous and rescuing behaviors that convey that clients
are helpless and unable to develop or rely on other sources of support. Cli-
ents (especially those whose attachment style is anxiously preoccupied or
disorganized) should, in most cases and in accordance with clearly deline-
at boundaries regarding the therapist’s availability and personal time,
be encouraged to be more independent and to rely on others besides the
therapist. On the other hand, the stress associated with separations should
not be minimized or ignored and dependency not considered a weakness
or a sign of pathology. In fact, building healthy dependency and interde-
dependence based on secure attachment is a goal of treatment (Steele et al.,
2001). Actions must be selected in response to client needs and after dis-
cussion about strategies and options that would be helpful. On occasion,
separations are so difficult that hospitalization or participation in a partial
hospital or other recovery program is necessary. Although not necessarily
the treatment of choice, these options need to be considered for the client
who lacks a support system, cannot tolerate the therapist’s absence and
felt support without decompensation, and cannot function or abide by the
terms of an established safety plan.

Summary
This is but an abbreviated list of the possible transference reactions asso-
ciated with complex interpersonal victimization. There are innumerable
variations that emerge according to the client’s unique experience and
character that should be expected and welcomed as important communi-
cation and addressed individually. In the course of treatment, when ther-
apeutic interventions enable clients to recognize rather than simply repeat
posttraumatic transference dilemmas, they become more aware of the costs
of both their victimization and the adaptations they have made to carry on
in life despite abuse, betrayal, abandonment, or exploitation. At this point,
clients often feel overwhelmed or frightened by the depth and breadth of
their unmet needs and furious or despondent about the harm done and the
opportunities missed as a result of having had to focus their lives on sur-
vival. These existential issues arise when complex trauma survivors become
able to fully and accurately understand the traumatic challenges they have
faced and the alterations that they had to make in their life paths and ways
of living. These can be very poignant times in the treatment where the
empathy of the therapist is especially important.

Awareness and acceptance of trauma-related transference issues need
to be addressed gradually and in doses. It is essential that therapists help
clients to recognize not only what has been lost or damaged by trauma
but also what remains intact or can develop in themselves, their relation-
ships, and their lives. Where warranted, the imbalance in past and current
relationships needs to be analyzed and changed. Some relationships will
no longer be acceptable or satisfactory, primarily those that were based on
traumatic reenactments or beliefs about self and others that were shaped by
trauma but do not reflect the client’s (or their significant others’) true self or
best interests. Thus, crucial therapeutic gains in awareness can sometimes
place clients at a crossroads in their personal relationships, feeling alone
and unsupported just when they are genuinely most able to recognize and
benefit from support. Clients are apt to be very dependent on therapy dur-
ing this time (which most often occurs during the transition from Phase 2
to the application of therapeutic gains to present-day life in Phase 3) until
more equitable and mutually satisfying relationships develop. Those family
members and friends with whom supportive, trustworthy, and meaningful
relationships are possible should be mobilized. A therapy group or self-help
group may be useful at this difficult juncture as well to provide another
source of growth and support.

Countertransference responses are the next challenge for the therapist
working with clients with complex trauma histories. As with transference
dilemmas, countertransference must be assessed and analyzed based on the
information it can provide, as well as to determine by what means it can
best be managed so that it does not disrupt or derail the treatment.

COUNTERTRANSFERENCE THEMES,
ISSUES, AND REACTIONS

As observed earlier, professionals have no immunity from the dominant
societal attitudes toward interpersonal victimization and trauma (Kluft,
1990b), nor do they necessarily have knowledge of or training for vari-
ous extreme types of interpersonal trauma (e.g., incest; Courtois, 2010;
make diagnostic and therapeutic use of their own responses to the patient when they are aware of these typologies as related to the client's presentation and personality style (to this we would again add the client's attachment style, as well). This is especially needed for trainees and novice therapists (Neumann & Gamble, 1995).

In an early contribution to the literature on widespread countertransference behaviors, Renshaw (1982) categorized them as connoting avoidance, attraction, and attack, labels useful in identifying and addressing them. Avoidance refers to the desire to deny, escape from, or not see the situation as it really is. Trauma avoidance is generally based on such emotions as anxiety, discomfort, repugnance, dread, and horror. Attack connotes moving toward, a voyeurism, fascination, a rescuing or overinvolvement, or arousal/stimulation. Attack is usually motivated by anger, disgust, blame, and condemnation of the trauma and its symptoms that are projected onto those involved in it, including the client. The two problematic therapist positions having to do with empathic strain, identified by Wilson and Lindy (1994) and described earlier in this chapter, resemble Renshaw's categories: in one position the therapist avoids, disengages, and sets overly rigid boundaries, thereby abandoning the client and not providing needed response and support; in the other, the therapist is attracted, and stimulated by the needs of the client or the particulars of his or her story or both, resulting in overinvolvement and blurred boundaries, sometimes including sexual contact. Both positions can involve aggression and power dynamics and can lead to boundary violations and revictimization. All of the countertransference responses described next fit into one or more of these categories.

Dread and Horror Leading to Denial and Avoidance

Therapists can be horrified when hearing a history of cumulative interpersonal victimization and subsequent revictimization and reenactments. Horror can lead to dread and fear and subsequently to defensive behaviors, such as the therapist's denying that the situation could have been that bad (even though doing so contradicts the therapist's emotional response), never bringing it up, refusing to discuss it, changing the subject, and encouraging the client to put it in the past to get on with his or her life. Although such reactions may be motivated by the therapist's and the client's understandable fear of making things worse or of the client's going crazy, they typically result in increasing the patient's isolation and despair. Circumstances such as these call for specialized supervision and consultation and for personal psychotherapy in some cases. When the therapist cannot get his or her negative reactions neutralized or under control, is unwilling to get consultation or training, or has other personal reasons not to be able to engage in the treatment, referral is indicated.
Shame, Pity, and Disgust

Horror and denial can lead to related emotions of shame, pity, and disgust that get projected onto the client and his or her behaviors, characteristics, or symptoms, thereby contributing to and reinforcing negative self-perceptions and feelings. From this position, the therapist might inadvertently convey that the client is irreparably damaged, corrupted or unlovable, a view that substantiates rather than changes the viewpoint already held by the client. Shame in the therapist is contrary to a positive sense of self and feelings of competence. Because shame involves internal representation of being devalued, therapists can develop concordant or complementary countertransference identifications with their clients, based on their own susceptibility to shame (Hahn, 2000). Their own shame can be activated, or they can internalize the projected shame of the client. Clients may defend against their feelings through avoidance, withdrawal, narcissistic entitlement, and even attacks on the therapist, who, in turn, may feel additionally incompetent, inadequate, and worthless. Mindfulness regarding personal feelings of shame and devaluation on the part of the therapist is necessary; if this is not adequate, consultation, supervision, and therapy are advisable.

Therapists who were never traumatized (or not as severely as their clients) and who had reasonably happy, nonabusive childhoods and “good enough” parents may be prone to feelings of guilt when they hear about the client’s experiences and their aftermath. In an attempt to protect the client against further pain and to relieve guilt, the therapist might conceal discussion of the trauma or the other’s will or oversolicitous. In this latter circumstance, the client is treated as fragile and exceptional and as needing constant special arrangements, labeled “vicarious indulgence” by Turkus (personal communication, 2008). Two major problems are typical of guilt or fascination-induced overresponse and rescuing: The client comes to expect it and may even want more, and the therapist begins to resent the rising expectations, demands, and neediness. If unrecognized and unaddressed, in cyclical fashion, feelings of resentment and anger fuel more therapist guilt, leading either to additional overindulgence or to acts of hostility.

Disgust is a powerful emotion that conveys revulsion and aversion. The expression of disgust is highly damaging, but it might be the best way the therapist has to protect his or herself from other powerful feelings, including fear, helplessness, incompetence, and shame. Active antipathy on the part of the therapist may also be a way to manage his or her own unacknowledged sadism. Therapist and client may shift positions as abuser and abused, in the process playing out sadistic-masochistic roles with one another, or mutual torture, per Cheferz (1997). Both client and therapist are demeaned, as roles are played out rather than identified and changed. Obviously, this is a very charged situation that requires intervention to get the treatment back on track. It would even be better to end the treatment than to continue one of ongoing and unremitting sadistic-masochistic enactments without resolution.

Guilt and Associated Helplessness

Therapist guilt might also result from feeling helpless to undo the client’s experience and from not having “magic powers” to make it all go away or make it stop hurting so much. The therapist might defend against this sense of helplessness by avoiding detailed discussion of the trauma, ostensibly to spare the client additional emotional pain. The therapist cannot undo the past or its effects but can accompany and support the client in identifying, accepting, and processing its repercussions, in the process, having a very different interpersonal experience. To do so, the therapist must learn about the trauma, no matter how horrific or gruesome, in sufficient detail to explore and understand it from the client’s perspective; however, some techniques such as EMDR help the client to do so imaginably rather than verbally. As described in the earlier section on secondary secrets, it is sometimes the most closely guarded secrets or the most shameful aspects of the trauma that have the greatest impact; therefore, they need to be uncovered and become open to discussion or processing. The analogy of “cleaning out an infection” provides a rationale for the process that counterbalances the therapist’s tendency to back away from details for fear of further injuring the client.

This said, and presented in Chapters 4 through 6, interventions must be carefully sequenced and paced when clients are asked to provide details and to approach and process the trauma. Per the phase-oriented model, factual information about the trauma is first requested during the assessment to provide a baseline of information. The facts and associated emotions are explored in more detail after the client has achieved a relative degree of safety and capacity for emotion regulation. The therapist’s careful inquiry and ongoing support play major roles in allowing the story to be told and analyzed.

Rage

Trauma details can stimulate indignation and anger about the abuse and victimization and its various players and circumstances (such as the perpetrator(s), passive bystanders or colluders, “the system,” cultural and ethnic beliefs and traditions, sexism and the status of women, religions that support rather than report abusive clergy, medical and insurance systems and procedures, colleagues who are not helpful or supportive, and so on). Quite illogically, these feelings can be displaced onto the client, who is viewed as somehow bringing on mistreatment and other victimization and because of his or her helplessness in the situation, but more specifically, because he or she exposes the therapist to it, causing him or her to feel emotional anguish. Although it can be therapeutic for the survivor to know that
someone is angry about what happened, the therapist must exercise care in not dumping anger on the client (victim blaming), a very familiar societal response to the traumatized (the second injury: institutional trauma) that is wounding in its own right. Therapists must own personal anger and pay attention to how the client responds to hearing that someone has angry feelings and outrage about his or her experience. Care is needed not to express it prematurely, before the client is capable of hearing and accepting it. When the feelings escalate to rage or become dysregulated, they are best dealt with outside of the therapy in consultation or supervision with professional colleagues or in personal psychotherapy.

Any projection of rage and other negative emotions onto the therapist, either through the transference or as a direct challenge to the therapist’s caring as discussed in the Doris case, may elicit strong countertransferences, including complementary anger and retaliation. The therapist may experience rage at being identified as a potential abuser and compared to abusive others. The therapist might also feel anger after repeated and consistent but futile efforts (and possibly going the “extra mile”) to prove trustworthiness. In some instances, the intensity of the survivor’s rage may so overwhelm both parties that a therapeutic impasse results (Pearlman & Saakvitne, 1994). Because the therapist’s inability to tolerate the client’s projected rage and negative transference reactions or to understand and cope with his or her own countermigration, rage can ultimately lead to a distancing from and rejection of the client and a premature termination of the therapy, the need for ongoing monitoring and consultation is underscored.

Grief and Mourning

Although the losses associated with complex trauma are not quantifiable, many therapists respond to them personally and grieve for what happened to the client and for all of the losses entailed (Boniello, 1990). This is the case in general, but therapists with their own trauma histories, histories of complicated bereavement or ambiguous loss, or those who have faced recent losses may be particularly affected. As with other emotions, clients can benefit when therapists share their grief and sadness about what happened to them. Responses such as these can provide support for clients’ grieving, as there may be few other venues in which to mourn. However, grief and mourning reactions should be carefully monitored with attention to their not further burdening the client. As with other personal responses that might need airing outside of treatment, consultation, supervision, or therapy might be called for. Group therapy and other support groups are an additional context in which clients bereaved by their trauma-related losses might mourn in the company of others with similar experiences and reactions. As described in Chapter 6, ambiguous losses and complicated bereavement often lack a sharing context in which to receive acknowledgment and support.

Victim as Fragile; Survivor as Self-Sufficient

A perspective that exclusively views the client as victim usually results in overprotection or rescuing (an attempt to compensate) while simultaneously conveying to the client that he or she is helpless and not capable. An overemphasizes the client’s frailty ignores his or her strengths, resiliency, and capabilities in a way that short-circuits skill building, emotional processing, and trauma mastery.

From the opposite perspective, the client with complex trauma can be viewed as a “super-survivor,” a hero or heroine who accomplished the extraordinary through superior resilience, intelligence, coping abilities, and self-sufficiency. This position is problematic due to its unrealistic glorification of the client’s personal resilience and a related downplaying of what was endured and its associated suffering. It does not provide adequate recognition of the reasons that these capabilities developed nor the price paid for being so “brave” and “capable.” The therapist with this perspective tends to reinforce defenses and self-sufficiency while discouraging emotional exploration and interdependence with trustworthy others.

Trauma Happens to Everyone

A related reaction minimizes or trivializes the client’s unique experience by emphasizing that trauma is ubiquitous and that most adults and children have traumatic exposures or experiences. Although this might well be the case, this perspective assumes that all victimization experiences are the same or similar, ignoring essential differences in type, degree, severity, duration, subjective experiences and reactions, and so on. The therapist with such a priori views presumes to know about the survivor’s experience and, on this basis, prematurely forecloses discussion of the details of the client’s past or its individual meaning.

Language Use

Both therapist and client may defend against the reality of experiences of trauma by using muted, indirect, and inaccurate language. Such neutered terms as “contact,” “sexual experience,” “seduction,” and “sexual affair” can minimize the coercion, abuse, assault, rape, violence, and subjugation that the client reports. Some clients are unable to describe what happened to them with any directness or precision and resist using the word that is most accurate or descriptive (e.g., “rape,” “incest”). It is advisable initially for the therapist to use the client’s muted language but, over time, to encourage the use of more direct and accurate terminology.

A contrary situation arises with clients who are able to use direct words and wording (such as “rape” and “fuck” and accurate language for body parts) and those who are able to graphically describe what happened
Privileged Voyeurism

Privileged voyeurism refers to an excessive interest in and inquisitiveness about the details of victimization, especially those that are extreme, sexual, and that involve taboo activities. In its more general form, the therapist treats the client as an object of curiosity for having been involved in deviant, abnormal, or forbidden events and behaviors, making him or her feel even more like an aberration (often the case with incestuous abuse [Courtois, 2010]). In more specific form, the therapist focuses excessively (and sometimes exclusively) on the sexual aspects and details without similar attention to other issues. Clients who have experienced this response describe having felt pressured to detail the most intimate and the most humiliating and degrading sexual aspects and of being constantly redirected to them. The therapist comes across as spellbound or tantalized, causing the client to feel objectified and exploited and therefore revictimized. Responses such as these can remain hidden and not presented in supervision or consultation due to the therapist's secret gratification and related shame (or shamelessness). The therapist who admits to feeling overly stimulated or excessively curious (especially one without outside support or who practices in isolation or is in the throes of personal crisis) is in need of collegial consultation and supervision (and possibly personal psychotherapy). Keeping such responses hidden can lead to their reinforcement and, in the worst case, result in sexual transgressions and other actions that are coercive and violative.

Sexualization of the Relationship

As discussed in Chapter 2, adult survivors' sexual aftereffects range from a total blunting of sexual interest and response to indiscriminate and compulsive sexual behavior. At one end of the spectrum, some survivors are sexually naive, inexperienced, or shut down. At the other end, some are highly sexual and seductive and may be sexually addicted or may be conditioned to compulsive sexualization or to use sex to be powerful and in control, as a means of developing and maintaining relationships or of devaluing them, or to self-soothe or blunt ongoing distress. Unfortunately, both extremes can enthrall the therapist. The innocent, inexperienced, or "sexually anorexic" client may evoke protective and teaching tendencies in a therapist who may
clients by male therapists (Armsworth, 1989; De Young, 1981; Kluft, 1990a, 1990b). Less commonly recognized is sex between same-sex clients and therapists, yet such contact does occur in numbers that are not yet determined. By virtue of the power differential involved and the violation of trust inherent in such a relationship (among other prominent dynamics), sexual abuse by a therapist recapitulates the original transgression trauma as it counters trust and safety and trauma mastery, the goal of treatment. The client suffers another significant relational betrayal-trauma and receives additional proof of the distrustworthiness and venality of authority figures as well as his or her own “evil eroticism.” Cheferetz (1997) observed an underrecognized dimension of erotic transference and countertransference: that it can be highly sadomasochistic when it involves power and control. In this scenario, therapist and client may reciprocally play out power dynamics and each alternately take on the role of victimizer or victim. This is discussed more in the next section on role enactments in transference and countertransference.

Therapists who are secure in their sexuality and who address and work through attraction and power issues can then identify with the victimized client and model appropriate behavior. With them, the survivor client has the opportunity to experience a caring relationship in which appropriate sexual boundaries are maintained and sex can be distinguished from affection and from aggression. Much information is now available on the dynamics of sexual abuse of clients by therapists, a major ethical violation in all mental health and medical professions and a crime in every jurisdiction. Bridges (1994), Gabbard (1989), Pope (1990, 1994), and Pope and Bouhoutsos (1986), among other researchers, have found that most mental health training does not attend to issues of therapist-client attraction, including sexual attraction. Trainees and therapists are therefore often on their own in determining how to respond to their own attraction to the client, to the client’s expressions of love and attraction to the therapist, or to either the client’s or therapist’s frank propositioning or seduction of each other. Pope (1994) wrote the book Sexual Involvement with Therapists and, he and his colleagues wrote the book Sexual Feelings in Psychotherapy (Pope, Sonne, & Holroyd, 1993) to address this oversight and to provide needed training and discussion. A training videotape on the topic of sexual feelings in psychotherapy is available from the American Psychological Association that provides stimulus clinical vignettes for the viewer to watch and respond to. It also provides opportunities for discussion by providing stimulus questions.

PROJECTIVE IDENTIFICATION, ENACTMENT, AND COMMON TRANSFERENCE-COUNTERTRANSFERENCE ROLES AND POSITIONS

Projective Identification

Projective identification is another way in which the client communicates. Through this implicit or unconscious process, he or she projects disowned aspects of him- or herself and personal experience onto the therapist, who becomes the “emotional load-bearer” and can learn much about the client through his or her own feeling states and reactions as well as physical responses. As discussed previously, therapists can become entranced within their client’s experience, actually feeling the feelings that the client does not recognize or routinely disowns, displaces, or disavows. Although it can be disconcerting for the therapist, it is yet another relational process by which the client can come to be “known” by what has been projected onto the therapist.

Enactment

How does the therapist understand and make best use of the unconscious communications of dissociative and posttraumatic clients that are contained within the projective identification, enactments, and transference-countertransference? Quoting Baker (1997), who analogized the process to a dance in which both partners learn steps and movements that, over time, become attuned and automatic:

How alike this is to the therapy process. It is what we, as therapists, strive for, those aspects of the interaction which are beyond words and cognition, where therapist and patient may attain new levels of understanding through “the dance.” This is the realm of knowing without saying, that which takes place in the countertransference through the experiencing and later understanding of projective identifications and enactments. Although enactments can be destructive (frequently the beginning therapist is astonished to beware of enactments), I propose that many are not only constructive, but vital to be able to be with the patient in her world. (p. 214)

Baker further proposed that the therapist understand enactments as inevitable and as explanatory of the client, who communicates authentically but implicitly and in primitive somatosensory ways as a result of having been harmed so early in the developmental process. Traumatization left the client with somatic imprints in his or her “right mind,” but in conditions of speechless terror and without the words to describe or formulate experiences and feelings. Enactments put these internal experiences into action. Wallin (2007) described enactments as involving

behavior—including verbal as well as nonverbal behavior. But even when enactments are played out in speech (as they often are in therapy) their essential meaning lies not in the words that are spoken but, rather, in the nonverbal subtext generated by what the words actually do.

In an enactment of transference-countertransference, what is enacted, verbally and nonverbally, is a particular kind of relationship. It could be a parent-child relationship or a romantic relationship, a relationship of allies or of adversaries, a relationship that feels safe or one that feels perilous. The variations are probably limitless, depending as they do upon the interaction of two unique individuals...
Enactments are the scenarios that arise at the intersection, so to speak, of the unconscious needs and vulnerabilities of the patient... and the therapist. In an enactment, aspects of the therapist's representational world—the legacy of her original attachment experiences—are unconsciously activated and lived out. Exactly the same is true for the patient.

To the extent that enactments continue to unfold outside awareness, they usually impose limits on what can be experienced and understood; in this way they make the therapeutic dialogue less inclusive and less collaborative. To the extent that they can be made conscious, however, enactments have the potential to provide access to highly significant, as-yet-unrecognized facets of the patient and the therapist and the relationship that they share. (pp. 270–271)

Enactments can be repetitive, especially when their meaning remains unknown, unrecognized, and unexplored. They may involve full-fledged reenactments of traumatic experiences or more particular to the therapeutic dyad. As with other aspects of relationships, they can be identified, discussed, and used as reparative for what they represent from the past. Due to their role, therapists move from the position of participant to participant—observer as they attempt to discern a specific enactment and bring it to the client’s attention for discussion and interpretation. It is in this way new information and new ways of being in relationship become open to the client.

Eight Common Transference–Countertransference Positions

Davies and Frawley (1994) identified

eight relational positions, expressed within four relational matrices, alternately enacted by therapist and survivor in the transference and countertransference that repeatedly recur in psychoanalytic (and other forms of therapy) work with adult survivors of childhood sexual abuse. These positions include: (1) the uninvolved non-abusing parent and the neglected child; (2) the sadistic abuser and the helpless, impotently enraged victim; (3) the idealized, omnipotent rescuer and the entitled child who demands to be rescued; and (4) the seducer and the seduced. (p. 166; authors’ italics)

These eight positions do not account for all possible manifestations of the transference or countertransference and they are likely to vary with other complex trauma subpopulations (e.g., refugees and survivors of political repression), yet they occur with sufficient regularity that the therapist treating complex trauma should be familiar with them. They are compatible with the attachment positions and manifestations described in Chapter 9 and with the transference themes discussed earlier in this chapter. Used together, they deepen the therapist’s understanding of the client and of the relational “dance” they engage in over the course of treatment. We touch on their most pronounced manifestations here. For additional discussion, the reader is referred to Davies and Frawley (1991, 1994).

The Unseeing, Uninvolved Parent and the Unseen, Neglected Child

According to these authors, this transference–countertransference paradigm is often the first to emerge in the treatment of complex developmental trauma. As most child abuse and interpersonal traumatization are not recognized, “seen,” or responded to, one aspect of the internal world of the abused child and later the adult is a relationship between a neglectful, unavailable, nonresponsive parent and an unseen, neglected and abused child. Within the transference–countertransference, the client sequentially enacts one or both sides of the relational scenario, as the therapist enacts the complementary role as the result of projective identification. At one pole, this client identifies with the parent and is withholding and distant from the therapist, who, in turn, feels unwanted, disconnected, and neglected. At the other pole, the client is the unseen, neglected child who responds to the therapist as he or she did to the parent and may have little or no compassion for him or herself in replication of the parent’s position. This may play out in the superficially compliant client who tries not to be seen as he or she seeks to please or take care of the therapist as he is not to be further abandoned, while his or her needs go neglected.

The Sadistic Abuser and the Helpless, Impotently Enraged Victim

The ambivalence associated with attachment to a parent whose abuse alternates with care (attack-ment/disorganized attachment) is played out in this relational paradigm. In one position, the client identifies with the parent/abuser and invades or intrudes upon the therapist’s physical and internal/psychological space, attempting to control the therapist by pushing boundaries. The therapist is likely to experience anxiety, discomfort, and dread in anticipation of sessions and to be overly involved in trying to please or placate the client or to be responsive to his or her needs, even those that are unrealistic and entitled. In this way, the therapist is attempting to please or offset the client’s demands, much as the client did as a child to stave off abuse. Self-destructiveness may be another way of identifying with the perpetrator while sadistically terrifying and victimizing the therapist (some therapists describe being held hostage by their fear of the client’s demands and potential for dysregulation and decompensation, and/or self-injury, suicidality, acting out, etc.). At the other end of the spectrum, the therapist may become aggressively reactive to the client. This involves a shift from the position of impotent victim to that of the sadistic abuser, a playing out of the sadomasochism that now involves identification with the powerful perpetrator rather than the powerless child. As described earlier, in some cases, this becomes a complete reenactment, resulting in sexual and coercive
contact between client and therapist, in identification with the perpetrator and reenactment of the original victimization.

The Idealized, Omnipotent Rescuer and the Entitled Child

The therapist may feel a powerful pull to play the role of omnipotent rescuer to an idealizing and needy client. This response may be an honestly assumed role that comes with being a helping professional; however, it might also result from the therapist’s overgratification at being needed and appreciated. It can also result in the therapist being overly intellectual or professional in working with the client in overly cognitive ways. If unrecognized or unaddressed, it can result in the vicarious indulgence described earlier that plays to and reinforces entitlement. In another variation, it might also mimic what the client did to placate the abuser as a child, or the client might reenact that scenario by taking care of the therapist and responding (or catering) to him or her, in this way becoming the rescuer and the therapist the rescued.

The Seducer and the Seduced

Clients (especially those who were abused after a relationship was developed (referred to in the literature as “grooming”) may behave in kind in their interactions with the therapist, being highly pleasing, giving them special attention, or behaving seductively. The client is literally re-creating how he or she was drawn into the relationship and demonstrating what is known about how “to do” relationships. Therapists may find themselves responding in kind, looking forward to these clients’ sessions, and becoming like the client, in a process of mutual seduction. With appropriate boundaries maintained, these feelings can be acknowledged and accepted as normal in human interactions; however, the client has the restorative opportunity to distinguish between situations in which they are used dishonestly to exploit and those in which they are authentic and benign. Both therapist and client can come to enjoy the positive regard and feelings of attraction they have for each other, similar to what occurs in healthy parent–child oedipal configurations. Its resolution allows healthy separation and individuation. Its expression and appreciation in a bounded and safe relationship is healing for the client and can be enormously satisfying for both members of the dyad, the benefit and reward of the hard work of complex trauma treatment.

CONCLUSION

Rarely are relational issues and paradigms so organized and linear as presented here. Real-life relationships and those inside the consulting room are much more diverse and complicated. Nevertheless, when transference, countertransference, enactments, and projective identifications such as those reviewed here come to light in the treatment, the therapist who has knowledge of them is more prepared to anticipate and manage them. As Chu so presciently wrote in his 1988 article on traps in trauma treatment, “Knowledge of them doesn’t prevent them from happening but it does allow the therapist to know about them ahead of time, to not have as much anxiety about them and to get out of them much more quickly” (Chu, 1988, p. 26). So too with trauma- and attachment-based reactions and counterreactions, transference and countertransference, projective identification and enactments: The therapist who has foreknowledge of them has a means of anticipating and understanding them, may not be as likely to get mired in them, and may therefore be able to identify and interpret them earlier in the interest of the client’s increased self-knowledge and symptom resolution.