Review article

Countertransference and psychic trauma

Mariana Eizirik*

Sidnei Schestatsky**

Laís Knijnik***

Luciana Terra****

Lúcia Helena Freitas Ceitlin#

* Psychiatrist, Hospital de Clínicas de Porto Alegre (HCPA), Porto Alegre, RS, Brazil. MSc. student, Graduation Program in Psychiatry, Universidade Federal do Rio Grande do Sul (UFRGS), Porto Alegre, RS, Brazil.

** Psychiatrist, UFRGS, Porto Alegre, RS, Brazil. Associate professor, Department of Psychiatry and Forensic Medicine, UFRGS, Porto Alegre, RS, Brazil. Preceptor, Resident in Psychiatry, HCPA, Porto Alegre, RS, Brazil. Coordinator, NET-TRAUMA, HCPA, Porto Alegre, RS, Brazil. Professor, Instituto de Psicanálise, Sociedade Psicanalítica de Porto Alegre (SPPA), Porto Alegre, RS, Brazil.

*** Psychiatrist, UFRGS, Porto Alegre, RS, Brazil. Invited supervisor, NET-TRAUMA, HCPA, Porto Alegre, RS, Brazil.

**** Psychologist. MSc. student, Graduation Program in Psychiatry, UFRGS, Porto Alegre, RS, Brazil.

Psychiatrist, UFRGS, Porto Alegre, RS, Brazil. MSc. in Public Health, Harvard University, Boston, USA. PhD in Medical Clinic, UFRGS, Porto Alegre, RS, Brazil. Associate professor, Department of Psychiatry and Forensic Medicine, UFRGS, Porto Alegre, RS, Brazil. Professor,

Resident in Psychiatry, HCPA, Porto Alegre, RS, Brazil. Coordinator, NET-TRAUMA, HCPA, Porto Alegre, RS, Brazil.

Received March 28, 2006. Accepted October 26, 2006.

INTRODUCTION

This article aims at reviewing important aspects of the relationship between countertransference and care of patients who were victims of psychic trauma. The treatment of traumatized patients is a potential source of psychic suffering to their therapists, due to the emotional burden involved and to the chances of evoking strong countertransferential reactions. A better understanding about this theme could contribute to an improvement in patients' treatment, besides allowing better protection and prevention of therapists' mental health.

We initially approach the psychic trauma, including considerations on posttraumatic stress disorder. Then, countertransference and its meaning in patient care, followed by the relation between countertransference and trauma are discussed. In the latter item, the concept of vicarious traumatization will be included, which is a phenomenon that has been studied and observed in care of psychological trauma victims.

REVIEW OF THE LITERATURE

Trauma

Trauma can be defined as a "situation in the individual's life defined by its intensity, by the disability the individual has to appropriately respond to it, by the disturbance and pathogenic effects caused in psychic organization."[1]

The concept of trauma has played a major role in Freud's early theories. By describing traumatic neuroses, he said that "they provide a precise indication that in their root there is a fixation on the moment of the traumatic accident (…) it is as if the patients had not ended the traumatic situation, as if they were still facing it as an immediate task, not performed." Freud inserts the trauma in the economic aspect of mental processes: "in the experience that, in a short period of time, brings to the mind an increase in excessively powerful stimulus to be normally managed or elaborated, and this can only result in permanent disorders due to the form this energy operates."[2]

Freud also defines all experiences in which an intense patient fixation is produced as traumatic. He concludes that there is a single cause for neurosis onset, which would result from the impossibility the patient has of dealing with an affectively very intense experience.

In *Beyond the pleasure principle*,[3] Freud describes the mental apparatus in relation to the external and internal environment through an analogy with an undifferentiated vesicle susceptible to stimuli. Such vesicle would be destroyed by the powerful energies from the external environment in case they did not have a protective shield, with the aim of filtrating stimuli and gradually releasing them using lower intensity to more internal vesicle layers. Traumatic would be "any excitements coming from outside that are sufficiently powerful to cross the protective shield."

Garland[4] added the relation with internal objects to the understanding of trauma consequences in the individual's mind. The deterioration of identity that occurs after traumatic situations would be associated with a failure in the belief in protection of "good internalized objects." The trauma would cause an exacerbation of primitive anxieties and fears, added to the external sources of these feelings, generating a collapse in the way individuals perceive the world, themselves and their defensive organizations. A traumatized individual would try to deal with the external event relating it to previously known internal object relations, aiming at giving meaning to something so horrible and overwhelming. The connection between past and present (that is, present event with past disturbing meanings) would be one of the causes for the difficulty in recovering an individual after a trauma.[4]

Shengold[5] developed, in relation to early traumas, the concept of **soul murder**, described as "partial or complete destruction of the developing – or even of the developed – mental apparatus and sense of identity ('soul')." This would be related to repeated and chronic traumatic experiences (super stimulations alternated with privations), intentionally imposed on the victim, time being the most important factor in trauma pathogenesis: the sooner it occurs, the more likely the child will be affected and the greater will be the damage.

Psychic traumas have been more frequently identified and treated over the past decades, based on the recognition of symptoms resulting from traumas in Vietnam War veterans and survivors of both World Wars.

The posttraumatic stress disorder (PTSD) was originally conceived as a normal response to an adverse event. After the PTSD was introduced in 1980 as a valid psychiatric diagnosis, studies of events pointed as possible causes of the disorder (for example, natural disasters, interpersonal violence) revealed that those forms of trauma were common in our daily life. It has been established that many symptoms that occurred after the trauma could be lasting or even permanent. This view changed the tendency of stigmatizing trauma victims with psychiatric symptoms as being “neurotic” or “weak,” showing a clear evidence of a prevalent psychiatric disorder causing significant suffering. Over the past decade, there has been an “explosion of knowledge on the prevalence and impact of traumatic stress and phenomenology, neurobiology and treatment of posttraumatic stress disorder.”[6]

PTSD is a syndrome characterized by the exposure to a traumatic event that involves death or severe injury, real or threatened, or a risk to one’s or other’s physical integrity, and its response involves intense fear, impotence or horror. Other criteria include persistent revivals of the traumatic event, persistent avoidance of stimuli associated with the trauma, numbness of general reactivity and symptoms of continuous excitability. Disturbance should last for more than 1 month.[7]

Studies on the prevalence of PTSD show that this is the fourth most common psychiatric disorder in the general population, affecting approximately 10.3% of men and 18.3% of women at a given moment of their lives. They also reveal that most people will have the experience of at least one traumatic event in their lives, and that about 25% of trauma survivors will have PTSD.[6]

Community studies describe PTSD prevalence in approximately 8% of the adult population in the USA. Individuals in risk situations (groups exposed to specific traumatic incidents) produce variable findings, with highest rates among survivors of rape, military combats, captivity, confinement or genocide with political or ethnic motivations.[7]

The world prevalence of PTSD in civilian populations varies from 37.4% in Algeria to 1.3% in Germany.[8]

A study carried out in Porto Alegre (Brazil) investigating the prevalence of sexual violence in adolescents showed that 2.3% of the interviewees reported having been sexually abused, attacked or raped, and 4.5% have witnessed a person being sexually attacked, abused or raped. An important finding to be stressed is that 27.9% of adolescents reported knowing people who were victims of sexual violence.[9]

Besides the suffering and loss caused by PTSD, trauma survivors have a higher risk of developing other psychiatric disorders, such as major depression, panic syndrome, generalized anxiety disorder and substance abuse disorder.[10]

Clinically, great part of loss and suffering caused by trauma exposure can be avoided, or at least reduced, if the diagnosis of PTSD or another psychiatric/psychodynamic diagnosis associated with the trauma is performed early and efficaciously treated.

According to Moore & Fine,[11] "environmental and physical circumstances resulting from trauma, the individual's reaction to the incident before the event itself, the archaic pathological attempts to dominate it and the support given by self-esteem and by objects will help to determine the outcome."

Initial care to trauma victims is crucial for further treatment. The professional's attitude, their conduct toward the patient and the destiny given to their own feelings may influence the treatment course and prognosis.

Countertransference

The contact with trauma victims usually generates intense countertransferential feelings in those who provide them care, not only for being dealing with people in great psychic suffering, but also due to the fact that traumatic situations reveal the therapists' frailty and impotence as ordinary people.

According to Eizirik & Lewkowicz,[12] “the evolution of understanding and using countertransference has made it become one of the key concepts for practicing psychoanalysis and analytic-oriented psychotherapy, making its study essential for professionals in those areas.”

There are currently three countertransference concepts to be considered. The classical concept sees it as something external, resulting from the therapist's neurotic conflicts, abnormal in the therapeutic process and disturbing it, in accordance with Freud’ original description.[12]

The so-called totalistic concept was proposed by Heimann,[13] in his paper *On countertransference*. Countertransference started being understood as a possible tool for patient’s treatment and understanding. It is conceived as all the therapist’s feelings and attitudes towards the patient – a normal event in the therapeutic process, originated by the patient and transmitted to the therapist by projective identification. Racker[14] defined countertransference as “the totality of the analyst’s psychological response to the patient,” a combination between agreeing (identification of each part of the analyst’s personality with the corresponding patient’s psychological part) and complementary (analyst’s identification with the patient’s internal objects) identifications.

The third concept, named specific, considers countertransference the analyst's specific reactions to the patient’s particular characteristics.[15] The therapist’s personal feelings, unrelated to transference and the patient’s projective identifications, are considered therapist’s transferences. According to Eizirik,[16] “countertransference is manifested whenever it is possible to identify that part of the patient’s self or their fantasies is being placed inside the therapist’s mind and causing a reaction, idea or behavior.” The relation of countertransference and the therapist's and patient’s gender and the stage of their life cycle should also be considered. Such variations of therapist/patient may represent many transference/countertransference configurations.[12]

Zaslavsky & Santos[17] point that, besides the psychoanalyst and psychotherapist, the contemporary psychiatrist cannot ignore the importance of using countertransference in their patients’ treatment. They consider that “the use of medication, its acceptance or not and treatment adherence may be more fully understood if psychiatrists use their feelings and try to understand the

bond established between themselves and their patients, whether they are psychotic, borderline or neurotic."

Countertransference and trauma

According to Klain & Paviae,[18] "countertransference in therapists treating patients with PTSD is differently stimulated in relation to the treatment of other psychopathologies." From the very beginning, there are great demands toward the therapist, among which is the patient's disbelief that they might be helped, something that is generally frustrating for the therapist's narcissism: "in the unconscious effort of making active what used to be passive, the therapist may feel attacked by the patient in such a way that the patient plays the role of aggressor and the therapist becomes the victim." Feelings of guilt are also common because the therapist has not been through similar situations to those experienced by the patient.

To preserve their view of the world and avoid their own psychic pain, therapists may become distant from these affections through mechanisms of negation, isolation or disbelief.

Klain & Pavie[18] believe that countertransference and empathy can be successfully used to treat patients with PTSD. It is crucial for the patient's recovery the construction of a safe environment, in which a mutual trust may be developed in the therapeutic process, as well as the ability of sustained empathy by the therapist along the process. In this new and predictable context, as affections and contents are differently expressed, the trauma has the possibility of being understood within a new system of meanings. The ability to a "genuine empathy is a *sine qua non* condition to allow the patient to perceive the therapeutic context as a situation of safety and protection and the right place to express anxiety and feelings of vulnerability."

Pearlman[19] states that the primary healing process in the psychotherapy of patients who were victims of sexual abuse in childhood takes place in the context of therapeutic relationship. This is the opportunity the patient has to relive and give new significations to damages occurred in their initial relationships. The author considers that the process of building a therapeutic relationship

is the therapy with trauma survivors, the therapist's self being essential to establish a clear and open therapeutic relationship.

Dissociation is a first-line defensive mechanism for many traumatized patients, distancing them from their affective experiences. Therapists sometimes are the first to have access to dissociated feelings, such as anger, sadness, shame and insecurity, which are at risk of being acted impulsively if not recognized and processed by the dyad. The experience of the patient's pain allows therapists to understand their reality deeply and intensely, which, besides the beneficial effect to establish a therapeutic relationship, may also generate powerful and complex countertransferential responses, common during the treatment of this type of patients.[19]

Pearlman[19] reinforces the importance that therapists working with trauma victims have of not remaining isolated. The author suggests continuous supervision and discussion of cases with colleagues, besides personal treatment, which would be "crucial for self-knowledge, self-observation and empathy toward the vulnerability of being a patient." The degree of comfort and familiarity that therapists have with their internal world, fantasies and affections, especially experiences of aggression, sexuality, anger and sadness, will influence their ability of accessing and understanding countertransferential responses. The therapists' professional identity and position in the development of their profession may also influence their responses towards patients, being different in therapists with more or less experience.

According to Dalenberg,[20] trauma victims are super-represented in situations of impasse or therapeutic failure, having lower success rates compared with people with no history of trauma, which may generate frustration and confusion in their therapists.

After 1 year treating patients who were victims of psychic trauma at Hospital de Clínicas de Porto Alegre, the therapists' feelings were surveyed after initial appointment with those patients, which exemplifies the theme being discussed: "sadness, pity, hopelessness;" "immobility, anger, contempt;" "feeling that the patient does not really want to be treated;" "interest, desire to help, surprise with their emotional balance;" "discomfort, irritation;" "desire that this had not occurred

with the patient, apprehension for thinking that it might happen to anyone;" "perplexity, curiosity;" "revolt, anger at the aggressor, affection;" "boredom, distance, which were changing along the interview into an increased interest;" "impotence, I felt I wasn't helping much;" "discomfort when listening to the reports about the trauma;" "anxiety;" "impression of being disconnected with the patient;" "solidarity, feeling of immobility and vulnerability by thinking that we are all subject to a trauma like this."

A major aspect of working with traumatized patients is the approach of feelings of guilt and shame that originate from the dyad. There is clinical and experimental evidence suggesting that therapists have countertransferential reactions to the trauma different from the feelings toward the traumatized patient, and that the therapists' preexisting thoughts and beliefs toward the trauma may affect the course of psychotherapy. Patients may take the therapist's rejection of the act committed against them as a rejection to their "inadequate conduct or pathological reactions; understanding this by the therapist may change the rejection into empathic connection."[20] Therapists may try to protect the dyad from "submerging in shame and guilt" by drawing attention to their tendency in idealizing them and considering them a "savior." The importance of the therapist's personal treatment is also stressed: "the power of transference is hard to be described and remarkable in being fully experienced."[20]

Another aspect to be considered about these reactions is the reaction to the patient's anger. Dalenberg[21] suggests that, if therapists are able to "modulate their anger with empathy," they will be able not only to feel it, but revealing it without expressing that the relationship has suffered an irreversible damage. The patient will then learn that there are continent relationships, loaded with emotions, but "not necessarily dominated by hostility." Learning that the "patient's angry cry may mean a suffered weeping can help the therapist avoid responding with counter-hostility."

An important phenomenon that usually occurs is the so-called vicarious traumatization, described as the experience of disturbing, painful and damaging psychological reactions, which are present in therapists working with severely traumatized patients. It is known that many therapists

get sad, depressed, hopeless, disillusioned, irritated and intolerant during that type of treatment. But vicarious traumatization goes beyond the psychological effects of empathy, being perceived as “a contagious, malignant process that can bring severe consequences to professionals.” Symptoms may be temporary and mild, or become severe and last for months or years.[22]

As victims describe the details of their trauma, parallel states of fear, hopelessness and displeasure are evoked in therapists. They become vulnerable to intrusive thoughts and disturbing dreams in response to the reports, or incapable of controlling their anger against the aggressors, becoming “hypercritical against the system, which allows such abuses and victimizations to be continued.”[22]

According to Crothers,[23] “people who work with trauma victims may experience deep, painful and disturbing psychological effects, which may persist for months to years after the treatment.” The trauma may be contagious, and the care team may feel “vicariously threatened,” as if they were a present witness, experiencing part of the terror, anger and despair of their patients. Repeated exposure to these experiences changes basic beliefs of the care team in relation to their own vulnerability.

The team ends up by sharing the patient's experience of impotence, which leads them to underestimate their own abilities and knowledge and not perceiving the patient’s resources and possibilities. It is important that victims may be able to share their experiences with others, and this possibility is a precondition for the restitution of a meaningful world. Based on that, the care team’s need of being able to get in touch with the patient's suffering and reality is evident, helping them to rebuild a more reliable and less threatening internal world.[23]

Pearlman[19] defines vicarious traumatization as “the transformation of the therapist's internal experiences, which results from an empathic relationship with the patient’s traumatic material.” It is a process, not an event, and includes the therapist’s affections and defenses against these affections. Therapists should be open and available to help the patient in their search for truth, but this

"empathic opening" is also a source of vulnerability, since therapists themselves also deal with the loss of beliefs in self-protection, safety, control and justice.

Vicarious traumatization is linked to countertransference, since it changes the therapist's self. As a more intense level of vicarious traumatization occurs, countertransferential responses may become stronger or less consciously recognized by the therapist. Such interactions may cause unfavorable results to the treatment, and therapists should remain alert to their influences.[19]

Schestatsky et al.[24] described the strong emotional responses of a team member after treating a victim of sexual violence. In clinical illustration, the therapist reported feeling anger, revolt, anxiety and impotence after the patient's dramatic report, besides physical symptoms, such as nausea and headache. She only felt relieved after being interviewed and discussing the case with other team members. The authors reinforce the need of supervision and information exchange and discussion with colleagues for therapists working with this type of patients.

The example above illustrates another phenomenon, called **second traumatization**, a sudden adverse reaction that may occur in the contact with traumatized patients, described by Figley[25] as "the emotional coercion experienced by people who are in close contact with a victim, especially therapists and relatives."

FINAL CONSIDERATIONS

It is evident the relevance of deepening the knowledge on emotional responses in those treating people victims of psychic trauma. This study brings benefits for patients' treatments, contributing not only to the therapists' understanding of these people's suffering, but also of the personal suffering and other disturbing feelings that may interfere with their therapeutic ability. The importance of the possibility therapists have of empathic contact with those people is clear, at the same time in which it preserves their ability of thinking and surviving the intense suffering arisen in both of them. Those abilities are crucial for a good development of the therapeutic relationship,

which, in its turn, is one of the main instruments to restore the internal trust and safety of traumatized patients.

REFERENCES

1. Laplanche J, Pontalis JB. Trauma ou traumatismo psíquico. In: Vocabulário da psicanálise. Lisboa: Moraes; 1976. p.678-84.
2. Freud S. Fixação em traumas: o inconsciente. In: Edição standard brasileira das obras completas de Sigmund Freud. Rio de Janeiro: Imago; Vol. XVI. 1976. p. 323-36.
3. Freud S. Além do princípio de prazer. In: Edição standard brasileira das obras completas de Sigmund Freud. Rio de Janeiro: Imago; Vol. XVIII. 1976. p. 17-50.
4. Garland C. Thinking about trauma. In: Scharff JS, ed. Understanding trauma: a psychoanalytical approach. London: Duckworth; 1998. p. 9-31.
5. Shengold LL. Maus tratos e privação na infância: assassinato da alma. Rev Psicoter Inf Adolesc. 1999;12:7-26.
6. Yehuda R, Davidson J. Psychological trauma and posttraumatic stress disorder. In: Clinician's manual of posttraumatic stress disorder. London: Science; 2000. p. 3-13.
7. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fourth edition. Washington: American Psychiatric Press; 2002.
8. Davidson J. Long-term and prevention of posttraumatic stress disorder. J Clin Psychiatry. 2004;65(1):44-54.
9. Polanczyk GV, Zavaschi ML, Benetti S, Zenker R, Gammerman PW. Violência sexual e sua prevalência em adolescentes de Porto Alegre, Brasil. Rev Saude Publica. 2003;37(1):8-14.
10. Shalev AY, Yehuda R. Longitudinal development of traumatic stress disorders. In: Yehuda R. Psychological trauma. Washington, DC: American Psychiatric; 1998. p. 31-66.
11. Moore B, Fine B. Trauma. In: Moore B, Fine B. Trauma. Temas e conceitos psicanalíticos. Porto Alegre: Artmed; 1992. p. 215-6.
12. Eizirik CL, Lewcowicz S. Contratransferência. In: Eizirik CL, Aguiar RW, Schestatsky SS, eds. Psicoterapia de orientação analítica fundamentos teóricos e clínicos. Porto Alegre: Artmed; 2005. p. 300-9.

13. Heimann P. On countertransference. Int J Psychoanalysis. 1950;31:81-4.

14. Racker H. Os significados e usos da contratransferência. In: Racker H, ed. Estudos sobre técnica psicanalítica. Porto Alegre: Artmed; 1982. p. 120-57.

15. Sandler J, Holder A, Dare C. Basic psychoanalytic concepts: counter-transference. Br J Psychiatry. 1970;117(536):83-8.

16. Eizirik CL. Entre a escuta e a interpretação: um estudo evolutivo da neutralidade analítica. Rev Psicanal SPPA. 1993;1(1):19-42.

17. Zaslavsky J, Santos MP. Contratransferência em psicoterapia e psiquiatria hoje. Rev Psiquiatr RS. 2005;27(3):293-301.

18. Klain E, Paviae L. Countertransference and empathic problems in therapists/helpers working with psychotraumatized persons. Croat Med J. 1999;40(4):466-72.

19. Pearlman L, Saakvitne K. The therapeutic relationship as the context for countertransference and vicarious traumatization. In: Pearlman L, Saakvitne K. Trauma and the therapist. New York: WW Norton; 1995. p. 15-34.

20. Dalenberg C. It's not your fault: countertransference struggles with blame and shame. In: Dalenberg C. Countertransference and the treatment of trauma. Washington: American Pshychological Association; 2000. p. 115-44.

21. Dalenberg C. Countertransference responses to anger and perceived manipulation. In: Dalenberg C. Countertransference and the treatment of trauma. Washington: American Pshychological Association; 2000. p. 173-98.

22. Blair TD, Ramones VA. Understanding vicarious traumatization. J Psychosoc Nurs Ment Health Serv. 1996;34(11):24-30.

23. Crothers D. Vicarious traumatization in the work with survivors of childhood trauma. J Psychosoc Nurs Ment Health Serv. 1995;33(4):9-13.

24. Schestatsky S, Ceitlin LH, Hauck S, Terra L. A vulnerabilidade do terapeuta e seu impacto sobre a função terapêutica. Rev Bras Psicoter. 2003;5(3):307-17.

25. Figley CR. Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized. Philadelphia: Brunner/Mazel; 1995.

ABSTRACT

This article aims at reviewing important aspects of the relationship between countertransference and care of patients who were victims of psychic trauma. The treatment of traumatized patients is a potential source of psychic suffering to their therapists as well, due to the emotional burden involved and to the chances of evoking strong countertransferential reactions. A better understanding of this process could be a valuable contribution to treatment outcome, besides promoting mental health protection and prevention for therapists.

Firstly, psychic trauma will be approached from its concept and definitions, including considerations on posttraumatic stress disorder and extending to countertransference reactions and their meaning in the context of traumatic situations. The impact of treating trauma victims will also be discussed through the relevance of vicarious traumatization, a phenomenon whose comprehension has been pointed out as crucial to provide better care to psychological trauma victims.

Keywords: *Trauma, countertransference, psychoanalysis, psychotherapy.*

Title: *Countertransference and psychic trauma*

Correspondence:

Mariana Eizirik

Rua Dona Laura, 228/707

CEP 904300-10 – Porto Alegre, RS, Brazil

Tel.: 55 (51) 3331.2594

E-mail: marianae.ez@terra.com.br