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The Dance of Empathy: A Hermeneutic Formulation of Countertransference, Empathy, and Understanding in the Treatment of Individuals Who Have Experienced Early Childhood Trauma

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Over the past 10 years, there has been a growing awareness of the profound psychological impact of early childhood trauma, including emotional, physical, and sexual abuse, on personality development and adaptation (e.g., Courtois, 1988; Herman, 1981). Most recently, researchers have discovered a relationship between early childhood trauma and the later development of severe personality disorders, such as borderline personality disorder (Herman, Perry, & van der Kolk, 1989; Westen, Ludolph, Misle, Ruffins, & Block, 1990) and multiple personality disorder (Braun, 1984). To date, the etiology of borderline personality disorder remains controversial. However, converging evidence suggests that such "disorders of the self" (Kohut, 1971) and related disturbances in identity, affective regulation, and interpersonal relationships may have their origins in highly traumatic childhood experiences.

The therapeutic process with adults who have experienced serious childhood traumas is often a challenging, complex, demanding, and protracted process. Early childhood trauma usually occurs within a relational context. It is often associated with serious boundary violations, intrusions, betrayals, and assaults on the sense of self. Thus, the "dance of empathy"

requires the utmost skill and delicacy in managing the complex transference–countertransference issues that inevitably emerge (see Wilson & Lindy, Chapter 1, this volume). Patients who have experienced early childhood trauma will often reexperience and reenact their role in previous abusive relationships within the context of the therapy relationship (Ganzarain & Buchele, 1986; van der Kolk, Boyd, Krystal, & Greenberg, 1984). These roles shift from being a victim to being identified with the aggressor, and, for the patient who has experienced intrafamilial abuse or incest, to being the "favorite" or "special" child (Ganzarain & Buchele, 1986). According to Finell (1986), projective identification describes an enactment or actualization wherein the therapist is unconsciously drawn into playing a role in the patient's reenactment of prior and or current abusive relationships. McCann and Pearlman (1990a) describe various trauma-specific transference reactions that may emerge within the therapy relationship. These may include fears that the therapist will recapitulate experiences of threat, terror, and boundary violations, a transference reaction that relates to a disruption in one's sense of safety and security. Likewise, the patient may fear that the therapist will repeat experiences in which the patient is betrayed, abandoned, and unsupported, reflecting transference themes related to previous violations in trust and dependency. The patient's ability to develop a safe and trusting relationship with the therapist will depend on the therapist's ability to genuinely listen, be with, and understand the patient's conflicted internal experience and malevolent objective world. This, in turn, challenges the therapist's capacity to "contain" intolerable affects (Parson, 1988) within a "safe-holding environment" (Winnicott, 1965) while modulating his or her own reactions of revulsion and shock to the often intense, affectively charged trauma-related material.

Over the years, increased attention has been given to the importance of countertransference reactions (CTRs) when working with traumatized individuals (e.g., Danieli, 1981; Haley, 1974; Herman, 1981). These reactions are important due to their impact on the nature and quality of the empathic stance of the therapist toward his or her patient. The pitfalls of either significant fluctuations in empathy or empathic failures have been well documented in the psychoanalytic literature (e.g., Kohut, 1977; Langs, 1974).

The dance of empathy between the therapist and the patient who has experienced early childhood trauma is conceived of here as choreographed and guided by the quality and accuracy of empathic responses, as determined by the countertransference of the therapist. As we will demonstrate in this chapter, this dance is a crucial factor for the successful treatment of individuals who have experienced early childhood trauma and abuse.

The first section of this chapter will explore and explain the importance of managing CTRs with patients who report early childhood trauma. Next, we will present a hermeneutic formulation of the relationship between countertransference, empathy, and understanding in treating individuals who have experienced early childhood trauma and abuse. This formulation is embedded within a psychoanalytic perspective. Finally, clinical examples will be presented to clarify and explicate the hermeneutic formulation of the dance of empathy.

CLASSICAL AND CONTEMPORARY FORMULATIONS OF COUNTERTRANSFERENCE

There are two types of CTRs: classical formulations, which refer to subjective reactions on the part of the therapist; and contemporary formulations, which refer to objective reactions on the part of the therapist (see Wilson & Lindy, Chapter 1, this volume). Classical formulations of countertransference refer to reactions on the part of the therapist that are specific, personal, and subjective, and that resonate with his or her prior understanding and experience. Contemporary formulations of countertransference refer to reactions on the part of the therapist that are universal. These reactions are universal in that anyone exposed to this material is likely to have characteristic responses. Likewise, these reactions are objective, in that they are related to specific trauma-embedded images and recollections conveyed by the traumatized patient.

In the classical conception of countertransference, the patient's transference reaction activates unresolved unconscious and conscious conflicts within the therapist, arising from his or her personal history (Freud, 1910). Freud also believed that the CTRs of the therapist could be useful to the extent that "everyone possesses in his own unconscious an instrument with which he can interpret [and understand] the utterances of the unconscious in other people" (cited in Marcus, 1980, p. 286). Marcus (1980) goes on to explain that the early view of the analytic process "was characterized as the resonance which takes place between the patient's unconscious and that of the analyst" (p. 287). CTRs of which the therapist is unaware oftentimes are a hindrance to establishing empathy within the therapeutic relationship. However, those personal reactions and feelings of which the therapist is aware are important tools that he or she must use to understand a patient's inner experience (Kohut, 1971).

Case Example One

Patient A. was a 36-year-old divorced mother who was referred for major depression and chronic fatigue. After a series of medical evalua-

tions, no physical cause for her condition was diagnosed. She reported being emotionally and physically violated by her hypercritical, volatile, and emotionally explosive mother. In an early session, the patient recalled a vivid memory of her mother repeatedly "stalking" her with a knife, then tying her up and locking her in a closet for hours at a time. The therapist became anxious and preoccupied in one of these sessions but was unaware that the patient's material had activated her own, as yet, unresolved rage toward her own controlling and capricious mother.

In a supervisory session, the supervisor noted that the therapist had defensively "moved away" from the patient's emotional experience and then refocused the patient on the material related to her mother's family background. This inquiry on the part of the therapist was understood as representing an intellectualized defense against her own unresolved history of victimization. Until the therapist was able to work through her CTRs aroused by the patient's material, the patient was unable to spontaneously produce further recollections of her own abuse.

Contemporary formulations of countertransference refer to universal reactions to the patient's presentation of traumatic imagery and recollections, a process described as secondary victimization (Figley, 1983) and vicarious traumatization (McCann & Pearlman, 1990b). Within this perspective, McCann and Pearlman (1990b) have described pervasive countertransference themes that often emerge in working with individuals who have been traumatized. These may include disruptions within the therapist's internalized object world. For example, the therapist's inner experience of his or her own sense of safety and power may be threatened by exposure to the patient's traumatic imagery. Likewise, the therapist's internal experience of other people as trustworthy and benevolent may be disrupted by the patient's vivid accounts of cruelty, violence, and betrayal perpetuated by other human beings. Exposure to the traumatic imagery and recollections of traumatized individuals thus has a profound effect on the emotional life of the therapist. Powerful affective responses may include horror, repulsion, shock, guilt, grief, and rage (Danieli, 1981; Ganzarain & Buchele, 1986; Lindy, 1988). Defensively, the therapist may react with disbelief, numbing, detachment, avoidance, and intellectualization of the patient's traumatic disclosure (see Wilson & Lindy, Chapter 1, this volume).

Vicarious traumatization, as distinct from classical conceptions of countertransference, is conceived of here as a "universal" reaction. Here the therapist's reaction is elicited by the material itself. In contrast, the classical view of countertransference presumes that the reaction of the therapist results from a resonance with his or her unconscious wishes and fantasies. Although vicarious traumatization does include a resonance with the therapist's own prior understanding and experience, we believe

that these reactions are universal and are therefore common reactions to horrific and shocking accounts of traumatic material.

Case Example Two

Patient B. was a 37-year-old mother of two who had recently discovered that her 4-year-old child had been sexually molested and ritually abused in a local day care center. She was suffering profoundly from rage, shock, revulsion, and guilt at what had been done to her child. She came into therapy as her depression worsened months after the disclosure and she was overcome by "irrational" guilt that she had failed to keep her child safe from harm. The patient's view of herself as a "good mother" was massively violated and she questioned whether she was capable of keeping her children safe. She even had thoughts of killing herself because she believed her children might be better off if she were dead. Her obsessive preoccupation with issues related to safety had become so extreme that it was interfering with her ability to function in her daily life.

The therapist, who herself was a mother, identified strongly with her patient's maternal feelings and reacted to the patient's trauma by becoming anxious and preoccupied about her own children's safety. She developed intrusive thoughts that her children would be harmed and suffered from terrifying nightmares that they had been kidnapped and killed by a stranger. In supervision, the therapist was ultimately able to use her own vicarious traumatization to empathize with her patient's deep guilt and despair at having "failed" her child.

CONJUNCTIVE AND DYSJUNCTIVE COUNTERTRANSFERENCE PROCESSES

According to Atwood and Stolorow (1984), there are two processes by which the therapist comes to understand and empathize with the patient by utilizing the CTRs. The first of these is considered *conjunctive.* Here, feelings and experiences shared by the patient readily resonate with and are assimilated into the internal experience of the therapist. These experiences, by definition, are easily accepted, empathized with, and understood by the therapist. The interpretation and understanding that result from conjunctive countertransference processes enhance empathy and facilitate the therapeutic process.

Case Example Three

Patient C. was a 23-year-old male graduate student who was referred for depression and anxiety. He complained of being unable to concentrate and focus on his studies due to a preoccupation with vivid and violent fantasies and intrusive thoughts of destruction to himself and

others. Shortly after entering therapy, early memories of his father beating him while in a drunken rage began to emerge. He was able to recall numerous instances of his father sadistically teasing and verbally tormenting him and his siblings until each was in a state of absolutely overwhelming fear and terror. His father would then in a systematic and brutal fashion sadistically beat each child with an extension cord until one was forced to confess to the father's psychotic, fantasized accusations.

The therapist of this patient himself had an alcoholic father and had experienced frequent beatings by him. Initially his CTR was to experience revulsion and anger at having to reexperience his own abuse through his patient's report of horrendous torture. Being aware of and modulating his own intense feelings allowed the therapist to "be with" and empathize with the patient's emotional experience of helplessness and vulnerability. The therapist was then able, by analyzing his CTR, to correctly interpret the violent fantasies of the patient as a defense against these painful memories and associated affects. In this case the therapist's ability to resonate with the experience enhanced his ability to readily understand and empathize with the patient.

The second process by which the therapist comes to understand the patient by utilizing a CTR is considered *dysjunctive* (Atwood & Stolorow, 1984). Here again, there is a resonance of feelings and experiences shared by the therapist and patient. The therapist "takes in" the patient's material, but then alters the configuration of the patient's experience in accordance with his or her own prior experience and understanding. The therapist may then react to or interpret the information from the patient in a way that leads to a misunderstanding of the patient's experience, a Type 1 CTR (see Chapter 2, this volume). Using the metaphor of the dance, the therapist misses a beat, and thereby incurs a possible failure of empathy and understanding of the patient. The resulting loss of empathy and understanding can result in the patient experiencing feelings of rage, rejection, abandonment, and estrangement. These failures in processing CTRs often lead to a recapitulation of a traumatic assault to the sense of self, in which the patient feels that he or she is not seen, heard, understood, and acknowledged by significant others. It is now understood that these mismanaged dysjunctive countertransference processes may lead to a retraumatization of the patient. If these processes are not carefully considered, understood, and monitored within the emotional life of the therapist, the resulting reactions may precipitate a rupture of the empathic stance of the therapist. More importantly, if left unaccounted for, these reactions may undermine and threaten the therapeutic relationship as a whole.

With an awareness of when and how a dysjunctive CTR occurs, the therapist can correct his or her reaction. By recognizing how his or her

own subjective experience and prior understanding taints and distorts his or her understanding of the patient's experience, the therapist can experience a more accurate and empathic understanding of the patient's subjective experience. Thus, by utilizing the reaction of the patient to an incorrect or threatening formulation based on a dysjunctive CTR, the therapist's corrected dysjunctive awarenesses can effectively aid in clarifying for the therapist the internalized object world of the patient.

Case Example Four

Patient D. was a 34-year-old married mother of three who was self-referred for treatment due to depression and "chronically low self-esteem." She reported that her father died in an auto accident when she was 7 years old. Patient D. described her mother as an "able-bodied caretaker" but emotionally cold and distant when interacting with her and her siblings. On numerous occasions the patient described waking up in her bed at night to find her mother fondling her. These experiences, while terrifying and confusing for the patient, were also the only times she felt any warmth from her mother.

In an early session the patient reported a dream in which she was being chased and then devoured by a large female bear. The therapist interpreted the dream as meaning that the patient wished to merge with and be nurtured by a fiercely protective, maternal object. Her empathic response, aimed at decreasing the anxiety and arousal caused by the material, only seemed to increase the patient's agitation and discomfort. Clearly, the interpretation and reassurance precipitated a highly traumatic experience for Patient D. Only when the therapist came to understand that her own desire to be closer to her own mother was incorrectly assimilated into her understanding of the patient's experience, was she able to step back, listen, and understand the meaning of this incident.

When the therapist corrected her dysjunctive CTR, she then understood the patient's internal experience as one in which she feared encroachment and annihilation by a devouring mother. Only when she shifted her understanding to the meanings conveyed by the patient, was the therapist able to construct an effective intervention based on the patient's inner experience and object world.

In summary, a breakdown in empathy (empathic strain) precipitated by unconscious or unresolved CTRs poses a serious threat to the therapeutic process when treating patients who have experienced early childhood trauma. Possible consequences include premature termination of treatment, retraumatization, and/or a repetition of earlier experiences of confusion, misunderstanding, and neglect within significant interpersonal relationships.

What has not been fully explicated is a conceptual formulation of the exquisitely complex process by which a therapist develops and maintains

a consistent empathic stance with patients who report detailed accounts of vivid and horrific traumatic experiences.

HERMENEUTICS AND THE DANCE OF EMPATHY

What will be explained here is a theoretical model that describes the circular process of monitoring CTRs to individuals in psychotherapy. The process is metaphorically conceived of as a spontaneously choreographed dance in which the therapist and patient move forward together in a fluid but deliberate pattern of interaction. It is this delicate process that creates the rhythm and tempo required for a patient to effectively work through and integrate threatening experiences. This model subsumes the primary functions of empathy, understanding, and countertransference.

Instead of a rational or empirical method for explaining this process, a hermeneutic conceptualization of understanding will be used to describe how to maintain an effective empathic stance with individuals who have experienced early childhood trauma. This hermeneutic conceptualization allows a more precise description of the complex processes of understanding and interpretation that are involved in psychotherapy.

Two important side notes need to be mentioned here. First, this hermeneutic formulation is broadly conceived within psychoanalytic and developmental frameworks. These frameworks allow for the most articulate description of the process. Second, the terminology used here is not entirely consistent with the formal terminology of philosophical hermeneutics. The goal here is not to create a major contribution to philosophical hermeneutics but to utilize the hermeneutic paradigm to describe in detail an important facet of the therapeutic process.

A Philosophical Hermeneutic Conceptualization of Understanding

Philosophical hermeneutics is the study of interpretation and understanding (Polkinghorne, 1983). In a hermeneutic inquiry, understanding, interpretation, and knowing are conceptualized as occurring in a circular or, more accurately, in a spiral organization (Polkinghorne, 1983). The inquirer approaches the object to be understood not with a preconceived notion or theory of what exists but with an openness that allows a natural unfolding of the phenomenon in order that it become revealed and understood. Yet to know and understand an object or phenomenon, it must resonate with what the inquirer or interpreter already knows and understands from his or her prior experience (Palmer, 1969; Polkinghorne, 1983). In order for this to occur, however, the inquirer must approach the

phenomenon or object empathically (Mueller-Vollmer, 1989). According to the philosopher Wilhelm Dilthey, it is from an empathic position that the unknown phenomenon can resonate, resound, and move with what is already known and understood by the inquirer (Mueller-Vollmer, 1989).

Figure 4.1 shows the internal movement of the inquirer or "knower" to the object to be understood or "known." The arrows in the diagram demonstrate the reciprocal interaction of the part to whole configurations (spiral) between the inquirer and the object to be understood. It is through this process that an understanding of the phenomenon can emerge. According to the hermeneutic paradigm, it is only through repeated experience with and exposure to a phenomenon from an empathic position that a true understanding of that phenomenon can emerge within the inquirer. In other words, the reciprocal interaction is an ongoing, repetitive process that includes a constant revision of and/or reconsideration of the phenomenon due to new information obtained about it during each exposure.

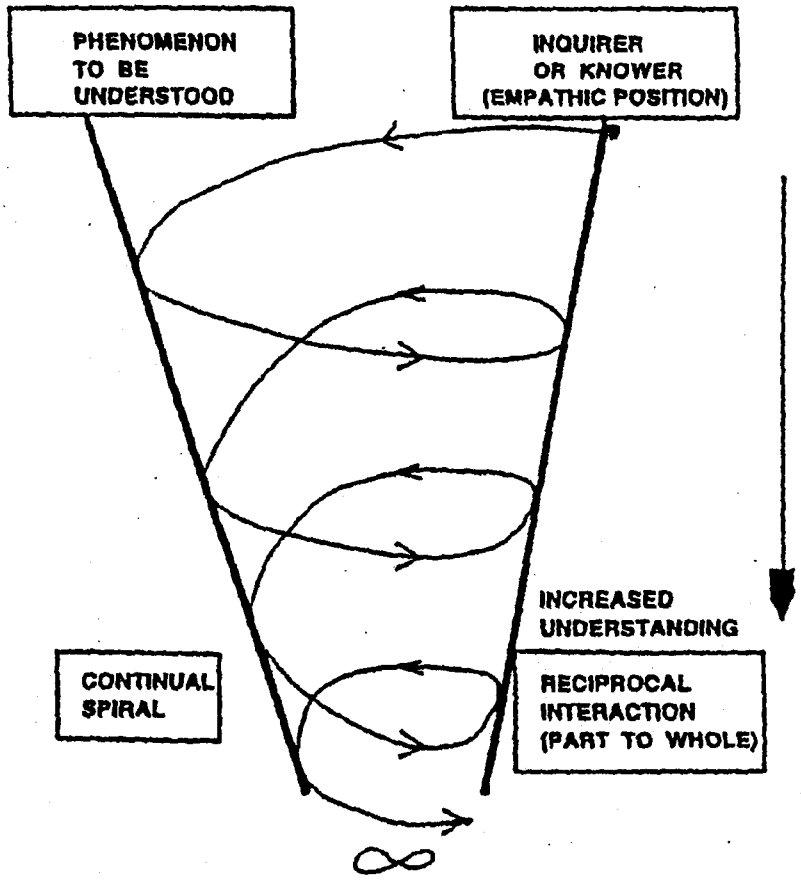

FIGURE 4.1. Philosophical hermeneutics.

A Hermeneutic Conceptualization of Therapeutic Countertransference and Empathy

This philosophical conceptualization of hermeneutics will now be described within the context of psychotherapy. This same empathic position is essential in understanding the inner experience of another person. Effective empathy allows the therapist the openness to experience and eventually understand previously unknown and unfamiliar material offered by the patient. The therapist achieves this effective empathy by allowing the experience of the patient to resonate, resound, and move with what is already known and understood by the therapist. In this formulation of understanding, then, contrary to philosophical hermeneutics, it is essential that the emotional and subjective experience of the therapist be considered. Now countertransference becomes an essential element for the therapist to consider when attempting to understand the patient.

Figure 4.2 shows the movement of the therapist as he or she first encounters the patient to be understood. The therapist approaches the patient not with a preconceived judgment of the patient's experience but

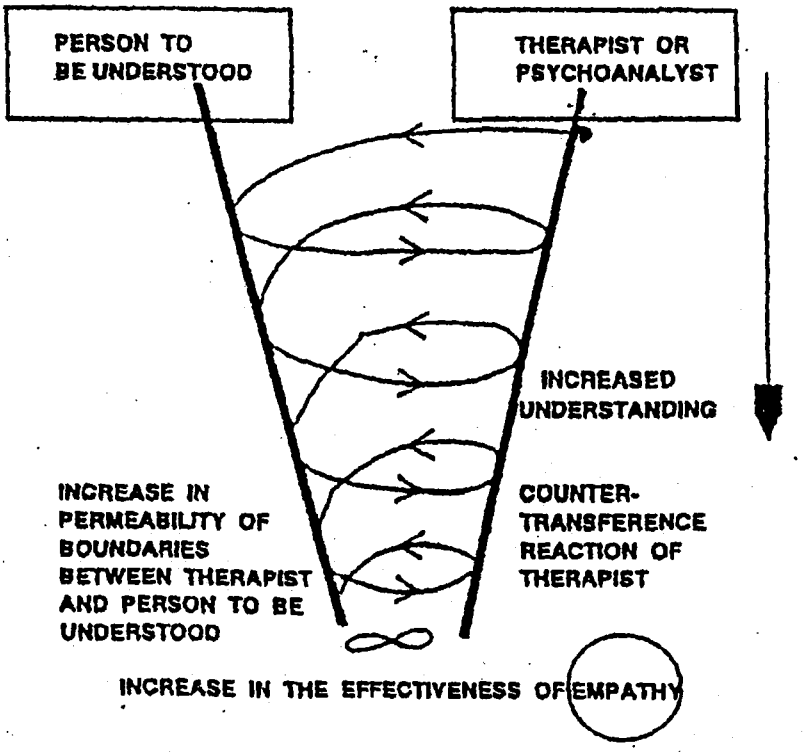

FIGURE 4.2. Hermeneutic formulation of countertransference, empathy, and understanding.

rather with an openness that will allow for an unfolding and revealing of that patient's inner experience. Through a consistent monitoring and evaluation of CTRs, the therapist can modulate his or her responses so that the most effective and appropriate empathy is maintained. As there is an increase in appropriate empathy, the patient will more freely explore and reveal material about himself or herself. Now a greater understanding of the patient's experience can emerge.

In the early stages of psychotherapy, a solid, impermeable boundary often exists between the therapist and the patient. That solid, impermeable boundary effectively blocks the therapist from entering into and understanding the inner experience of the patient. In effective psychotherapy, however, as the therapist's understanding of the patient and accuracy of the empathy increase, the once solid and impermeable boundary between the therapist and patient becomes permeable. Now the therapist can more effectively "be with" the person (Heidegger, 1962) and can continuously engage with him or her when it is appropriate. In this fashion, threatening experiences can be explored, revealed, understood, and then worked through. Although the boundary is conceptualized here as becoming more permeable, it is never to be broken or threatened by the therapist. Boundary loss will most assuredly lead to a retraumatization and a threat to safety and containment for the patient.

The Completion of the Hermeneutic Spiral: The Dance of Empathy

Within the hermeneutic spiral, the dance of empathy is choreographed through a mediation between (1) the quality of empathy, (2) the depth of the therapist's understanding of the patient, and (3) the therapist's awareness of his or her CTRs aroused by the patient's material. It is through this dance that the fluctuations in the empathic position remain beneficial for the patient.

The therapeutic process of understanding is considered to be the movement from the therapist's initial judgment of the meaning of the patient's internal experience to a qualitative change in that meaning due to a reciprocal interaction between the detailed parts of the patient's internal experience, and the whole of his or her life story. The proper empathic stance enables the therapist to secure a more profound understanding of the patient's experience. It is through effective empathy and the monitoring of CTRs that an understanding of another person's inner experience is possible. The hermeneutic process of understanding involves the therapist deriving a preliminary understanding of the patient and then revising and considering new possibilities through a reciprocal engagement with the patient. The goal of this dance, as exemplified in the

hermeneutic spiral, is twofold: for the therapist there is a greater understanding of the patient's internal experience and an increase in the permeability of the boundary between him or her and the patient; for the patient there is a greater understanding of himself or herself and a safe, contained environment in which to work through threatening material.

This more complete understanding and empathic stance allows the detailed parts of the patient's experience to be understood in terms of the whole person. Now those previously differentiated and separated parts can be more precisely defined, understood, and eventually integrated by the patient. For the patient there is an increased sense of feeling safe, cared for, and understood. The reemergence of threatening memories and affects will be experienced as less threatening and toxic and therefore, more readily accessible.

Understanding as the Mediation of Part-to-Whole Configurations

A lucid application of the hermeneutic principle is offered by Barker (1963), who described aspects of a person's behavior as tesserae, the tiny squares of marble or glass used in constructing a mosaic. Utilizing tesserae to construct a mosaic is analogous to the process by which the therapist comes to understand the experience of traumatized patients or any other patient for that matter. A therapist is exposed to tiny fragments or isolated parts of a person's experience. If the therapist attempts to understand the whole person from this fragmented piece of experience, little, if any, overall understanding will be possible.

Likewise, the whole person is understood only in relation to those parts of his or her experience. This repeated formulation and mediation of part-to-whole experience, and then whole-to-part experience, is essential for an overall understanding of the person. Thus, the therapeutic process with patients who have experienced childhood trauma is analogous to the process in which the tiny tesserae are utilized to construct and create the mosaic.

Implicit within the spiral of the hermeneutic process is the idea that an understanding of the patient's experience is never complete. In the balance of empathy, the therapist needs to both "be with" the patient and, at the same time, maintain separateness from the patient's experience. Crossing the boundary and resonating too closely with the patient's affective experience can result in a breakdown and threat to the empathic position. The therapist may then defensively move away from the patient's experience. The therapist, being led by his or her CTRs, either approaches or avoids his or her own emotional reactions to the material

presented by the patient. Consequently, the therapist may use his or her CTRs to move closer to, or away from the patient's emotional experience.

The Dance of Empathy and "Two-Stepping"

The dance of empathy involves a circular, reciprocal process of "being with" or moving closer to the patient's experience, and moving away from the material in order to maintain an appropriate boundary, empathic stance, and level of understanding. The choreography of the dance is determined by the therapist's awareness of and management of the countertransference. When an effective empathic stance is maintained over the course of therapy or within an individual session, the patient is able to freely "be with" the therapist and work through threatening experiences. In the dance of effective empathy the approach–avoidance of the therapist does not parallel the defensive processes of the patient. Instead the movements of the therapist complement the movements of the patient.

Utilizing the metaphor of a dance, this process resembles a ballet with Mikhail Baryshnikov and Twyla Tharp, each a seasoned, expert dancer. Although they had never danced together, it took only a few steps for each to anticipate, react to, and move with the other in a graceful, flowing motion. Here the partners moved together and away from each other in an intricate, spontaneously choreographed rhythm when no motion was prearranged, preplanned, or even rehearsed.

Applied to therapy, when the patient approaches threatening material, the therapist remains with him or her throughout the emergence of this material. Likewise, when the patient needs to step away from the material in order to regroup and work through the experience, the therapist reacts in such a way as to complement this movement and yet remain with the patient. This organized movement is determined, in part, by the therapist's ability to empathically "be with" both the patient and the material, while at the same time remaining separate from the experience. Within the context of this safe-holding environment, recovery can take place. This is the dance of empathy and understanding as choreographed by the countertransference.

CLINICAL APPLICATIONS OF THE HERMENEUTIC FORMULATION OF THE DANCE OF EMPATHY: A "FOUR-STEP" PROCESS

In this section, a "four-step" process for maintaining an effective empathic stance will be explicated. Table 4.1 outlines this process.

TABLE 4.1. Four "Steps" for Maintaining a Maximal Stance for Empathy and Understanding

Step 1: Listening
- a. Words (behavior)
- b. Feelings (affect)
- c. Transference projections and object relations

Step 2: Awareness of CTRs
- a. Past history, including traumatic experiences (classical formulations)
- b. Vicarious traumatization (contemporary)
- c. Conjunctive and dysjunctive CTRs
- d. Monitoring for CTRs
  1. Thoughts/ideation
  2. Feelings and visceral reactions
  3. Fantasies/dreams

Step 3: Monitoring of how CTRs are affecting effective empathic stance toward the patient
- a. Increased level of understanding of presented material
  1. Greater spontaneity
  2. Greater trust
  3. Increased insight on part of the patient
  4. Movement into areas that were previously threatening
  5. Less resistance to approaching traumatic material
- b. Increased permeability of boundary between therapist and patient
  1. Quality of therapeutic relationship
     - a. Safety
     - b. Containment
     - c. Analytic "holding"

Step 4: Completion of one cycle of the hermeneutic spiral: the "dance"

Step 1: Listening

Listening is an important facet of psychotherapy that receives relatively little attention in the contemporary psychotherapy literature. Here we will explicate the complex, delicate process of listening. We conceptualize the therapists' process of listening as it occurs on three levels of psychological experience: the words, feelings, and object relations the patient reveals during the therapy hour (B. Dujovne, personal communication, November 7, 1992).

The first level of listening concerns the words the patient uses to communicate his or her experience. The second level is indicated by those feelings expressed in the session, both verbally and nonverbally. The third and deepest level of listening is the level of transference projections and

object relation revealed by the patient in his or her interactions with the therapist. It is clear that in order for the therapist to fully listen to the patient, words, feelings, and object relation must be considered. Listening on these levels requires that the therapist approach the patient not with a preconceived notion of the patient's experience but instead with an openness to the material as experienced by the patient. In accordance with a psychoanalytic, object relations perspective, CTRs are an essential tool for understanding the patient, rather than an obstacle for the therapist to overcome.

The First Level

In the first level of listening, the therapist listens to the words and nonverbal behavior of the patient in order to understand that patient's experience. The language used by the patient often reveals complex motivations, unconscious conflicts, and meanings. Words are more powerful in therapy than is sometimes recognized. Words define inner experiences and selfobject representations. More important than the definition of words is the meaning of the words to the person. If a therapist presumes to understand the psychological significance of the words conveyed by the patient, he or she runs the risk of misinterpreting and misunderstanding the patient's experience. Horner (1985a) writes:

> The use of words that are assumed to have consensual meaning when it is more likely to have specific meaning for the patient should be clarified. Words like "rejection" in particular lend themselves to this kind of obfuscation. What constitutes a rejection for this person? What is the fear? the fantasy? the reaction? (p. 78)

Psychoanalytic listening involves fully exploring the meanings of the words and the patient's associations to those words in order to more accurately understand what the person is communicating to the therapist about his or her inner experience (S. Appelbaum, personal communication, November 17, 1992).

One prevalent example of listening gone awry is when therapist presume to understand the meaning the terms patients use when they first come to therapy. These include such ambiguously defined terms as "survivor" and "multiple personality disorder" (MPD). Frequently individuals who come to therapy refer to themselves as a "survivor" or a person with "MPD." Yet even in the professional community little if any shared meaning or understanding exists for these terms. The therapist may presume that the term "survivor" means the patient identifies with living through

an experience of trauma and that he or she has "survived" the experience to tell about it. Yet, this term may have different meanings for different people. Listening more carefully to how patients understand the term "survivor" may reveal numerous other meanings such as being unique, special, and part of a group. Vulnerable people who in the past have felt disconnected and alienated may now feel a sense of belonging and connectedness because they can identify with others who also see themselves as "survivors." Now the term means more than merely living through a traumatic incident or abusive past. It may signify that the patient is searching for something, such as belonging, specialness, and a sense of identity.

The following example illustrates the meaning of the term "MPD" for a young woman in ongoing psychotherapy. The therapist, not presuming to "understand" what the term meant to the patient, inquired as to what the term meant to her. The patient offered the following reflections in a letter to the therapist:

> "I talked to someone after the group and she sounds like a clear case of it [MPD]. It has been bothering me . . . because I really do not think that I have MPD and yet I am meeting people who really do and I feel out of place . . . I'm almost jealous of the ones who do have it . . . I'm afraid if I don't have it, then I will just be another ordinary patient with problems and I won't be anyone. . . . And if I don't have it, maybe you won't want to see me anymore because I won't be as important to you as your other patients who do have MPD . . . I think I am trying hard to produce it . . . but I do not have it. . . . It's crazy even to want to have it, I know . . . but you wanted to know my fantasy . . . my fantasy has been to be special in any way I can . . . and having MPD would make me special. It would make me be somebody . . . but I'm nobody and I'm not connected inside or out . . . maybe I'm making that up too. No I'm not . . . I just want to feel good about me and I don't."

Clearly what a term means to the patient is more important than the therapist's preconception and understanding of the terms and what implications it may hold for the patient. In therapy, words are powerful symbols by which patients reveal their inner experience and reality.

The Second Level

At the next level of listening, the therapist considers those feelings the patient reveals through his or her use of language and nonverbal behavior. Words reveal how the person has structured his or her affective experience and to what extent feelings are consciously recognized or defensively avoided. The therapist's ongoing inquiry into the patients' feelings

leads to a deeper exploration of meanings and associations. In the dance of empathy, the therapist uses his or her CTRs to understand the emotional experience of the patient. The emotional experience of patients with histories of childhood sexual abuse is conflicted, and it includes defended-against wishes, fantasies, and impulses. These patients may reveal feelings of shame, disgust, fear, and helplessness, as well as sexual arousal and longings for closeness. Understanding the complex constellation of feelings and their nuances requires that the therapist listen to the "music" and resonate with the deeper level of the patient's affective experience. The language used by the patient must be carefully considered as a symbolic reflection of his or her inner reality.

Case Example Five

A 40-year-old patient who had amnesia for most of her childhood reported a series of repetitive nightmares she had first experienced at age 9. These dreams involves being chased by a monstrous figure whose features would become swollen and distorted. This patient rarely expressed emotion in therapy and was very intellectualized. The therapist noted the use of the following words in a therapy session as the patient associated to the meaning of the dream: desperate, boxed in, trapped, smothered, choking, consumed, threatened, fleeing. The therapist reflected the words and commented that they were very strong and powerful terms. The patient looked startled but then spontaneously reflected upon the emotions underlying her inner experience.

The Third Level

At the deepest level of listening, the therapist considers the patient's object relations and internalizations as revealed through the transference projections. We believe that the ongoing relatedness of patient to therapist is the most important indication of the internal structure of the patient. This level of listening involves the greatest degree of inference on the part of the therapist. The accuracy of the therapist's listening at this level is dependent on his or her awareness of countertransference feelings as they are activated in the therapeutic relationship. Patients with histories of early childhood sexual abuse will unconsciously reenact their earlier abusive relationships within the therapy relationship. These patients often experience other people as malevolent, untrustworthy, and overpowering (e.g., Westen, 1989). The therapist may be aware of wishes and fantasies toward the patient that are in some way complementary to the projections and projective identifications of the patient. In the dance of empathy, the therapist must pay attention to and monitor his or her feelings elicited in interactions with the patient. The therapist thus comes to "know" and

understand the patient's object relations and transference projections through an awareness of his or her countertransference responses.

Case Example Six

Early in her treatment, a 34-year-old female patient with a history of verbal abuse and neglect by her father came to therapy session and immediately provoked the therapist by informing him that she did not want to talk about herself. The patient sat quietly for the next 20 minutes staring at a wall and playing with a piece of string in her hands. The therapist initially felt irritated and agitated, and then felt a strong pull to reprimand and demand that the patient tell him how she was feeling or why she was being provocative. Reflecting on his countertransference feelings the therapist noticed that this may have been exactly what the patient wanted him to feel. Now the therapist better understood what her experience had been like with her father. The therapist offered the following interpretation to the patient: "I wonder if your silence isn't a way to make me prod and poke at you to talk in a similar way that your father used to do to you?" The patient, feeling understood and "listened to" proceeded to freely express the feelings about her father whom she experienced as cruel, intrusive, and demanding.

Below, we describe the awareness of CTRs as the next "step" in understanding the patient's inner experience.

Step 2: Awareness of CTRs

In his work with Holocaust survivors Krystal (1984) said that therapy with traumatized patients is difficult at best. He states: "When dealing with individuals who have lived in a psychotic world and whose reality was beyond the scope of ordinary life and expectable environment . . . the therapist must be prepared to deal with extraordinary events, extraordinary ideas, and extraordinary feelings and responses on his or her own part" (p. 22).

As depicted in Figure 4.2 there is initially an impermeable boundary or significant psychological distance between the therapist and the patient. The therapist seeks to know and understand the patient initially by listening to the patient's words, feelings, and transference projections in an attempt to achieve an effective empathic stance. After listening to what the patient offers, the therapist then monitors his or her CTRs. In this way, the therapist comes to "know" and understand the patient's experience. It is the therapist's reaction to his or her feelings of countertransference that then determines the quality of the empathy. If the therapist resonates too closely with the patient's experience, he or she may react with a

defensive withdrawal from the patient or an incorrect interpretation. The patient will consequently feel misunderstood, attacked, rejected, abandoned, violated, or otherwise retraumatized. The therapist's task is to use his or her CTRs to "listen" at a deeper level to the meanings underlying the patient's communications about his or her inner experience. The therapist thus monitors his or her own ongoing reactions, adjusts his or her empathic stance, and therefore moves closer to an understanding of the patient's inner experience.

In terms of the hermeneutic spiral, the boundary between the therapist and the patient must be permeable enough for empathy to develop so that the therapist can come to "know" and understand the patient. However, empathic strain (see Wilson & Lindy, Chapter 1, this volume) develops when the boundary between patient and therapist becomes too permeable. The following is a description of the types of CTRs that must be monitored by the therapist in order to maintain a maximally effective empathic stance.

Thoughts/Ideation

The therapist may be aware of spontaneous, intrusive thoughts or images about a patient or the material during or after the therapy session. As the boundary between the therapist and the patient becomes more permeable and the therapist moves closer to an understanding of the patient's experience, the therapist's spontaneous thoughts may occur as a prelude to further disclosures by the patient. As the empathic connection between the patient and the therapist deepens, the spontaneous ideation of the therapist may represent a parallel process with the patient.

Case Example Seven

A therapist in supervision reported being deeply engrossed in listening to a female patient speak about her deep feelings of shame and disgust about her body during sexual intercourse with her husband. The therapist then reported being aware of a spontaneous, intrusive image of a young child being anally penetrated by a man's finger. This ideation was initially shocking and repulsive to the therapist but the therapist understood it to mean that the patient was trying to communicate something important about her experience. The therapist, being aware of and monitoring her CTRs, commented to the patient that the patient appeared to be struggling with something that felt shameful and dirty. Moments later, the patient revealed for the first time a memory of being anally penetrated by her father at the age of 4 while he was giving her a bath, an experience that was both stimulating and frightening.

If the boundary between the therapist and the patient becomes too permeable, and the CTRs are not monitored, vicarious traumatization may result. As described earlier, the therapist may experience intrusive thoughts, trauma-related visual imagery, and reexperiencing phenomena.

Feelings and Visceral Reactions

Powerful affective experiences on the part of the therapist who works with traumatized patients have been well documented in the literature (e.g., Danieli, 1981; Lindy, 1988). These feelings include guilt, rage, dread, horror, grief, sadness, shame, and the inability to contain intense emotions. Likewise, powerful visceral reactions such as nausea, diarrhea, headaches, and other somatic reactions may be experienced by therapists who work with these patients. The emotional responses and visceral reactions on the part of the therapist, if monitored and understood, can be used to facilitate the correct empathic position and a deeper understanding of the patient's emotional experience. Patients with a history of early childhood trauma often grew up in an environment in which their emotional experience could not be shared, listened to, or understood within the context of a safe, empathic relationship. These patients often report growing up with caretakers who were oblivious to their deep feelings of sadness, shame, fear, loneliness, and anger. In families in which incest occurred, deep emotional experiences had to be denied and, at times, split off from conscious awareness. Patients who grew up in these unresponsive, emotionally neglectful environments may report the development a "false self" (Winnicott, 1965). Here the deeper self-experience was masked by an external appearance of happiness and well-being. In terms of the hermeneutic spiral, then, the therapist comes to "know" and understand the patient's experience first by listening, and then being aware of his or her emotional reactions to the patient. The patient, unconsciously, may need to know that the therapist will be able to "hold" and tolerate these painful emotions before he or she is able to consciously acknowledge these experiences.

Case Example Eight

A therapist reported being aware of intense feelings of rage coupled with abdominal distress in sessions with a patient who reported being sadistically abused by her father. The therapist was not aware of the activation of her own unresolved anger. In supervision, she began to understand that the patient, who presented as extremely passive, helpless, and childlike, was terrified of her own angry feelings. The therapist

understood that the patient needed her to hold and tolerate these intolerable affects before she could acknowledge these feelings herself. The therapist did not prematurely interpret the patient's anger. Instead, the therapist used her CTRs to correctly empathize with the patient's terror of being killed should she express her rage. The patient gradually came to name her own emotional reactions and the therapist reported a decrease in her own rageful feelings during the sessions.

Fantasies, Dreams, and Other Symbolic CTRs

Therapists must be aware of fantasies, wishes, and dreams that emerge when they work with traumatized patients. Narcissistic wishes to be seen as "special," the only one who genuinely understands the patient, or the all-good, nurturing object are common Type II CTRs when working with these patients (see Chapter 2, this volume). In the case of therapists who themselves have an unresolved history of childhood abuse or neglect, an unconscious fantasy of undoing and/or transforming one's own traumatic history may be activated.

Sexual fantasies, voyeuristic impulses, and merger wishes may also be activated in work with these patients. The reality of eroticized or romanticized CTRs has long been recognized in psychoanalytic writings, with some authors suggesting that these reactions can be productively used by the therapist in long-term psychoanalytic therapy with deeply disturbed patients (Searles, 1959). In childhood development, early wishes and fantasies of being closed to, loved, and admired by a male (father) are in large part essential for females as they work through the developmental issues of relating to, loving, and being loved by a man (Horner, 1985b). In the case of father–daughter incest, infantile sexuality and oedipal wishes and fantasies are exacerbated, resulting in a tremendously ambivalent sense of power and shame in having won the father and destroyed the mother (Colletti & McCann, 1992). Some of these patients, then, may unconsciously seek to recapitulate or repeat these experiences in a relationship with a therapist who is unconsciously perceived as God-like and all-powerful. Likewise, homoerotic fantasies may emerge within the context of same-sex therapy relationships. Powerful wishes of the patient to merge with, be nurtured by, and protected by mother or father may activate strong, parental, loving feelings from the therapist. These complex transference and countertransference feelings pose potential hazards for both the therapist and the patient. The countertransference dilemma here is that the therapist may defensively move away from the patient and avoid exploring the patient's wishes and fantasies. These countertransference feelings are often conflictual for the therapist and therefore not

readily acknowledged by him or her unless CTRs are carefully monitored in supervision (Courtois, 1988). At the same time, however, the therapist's awareness of and monitoring of these CTRs can be utilized to enhance effective empathy for the patient's experience and conflicted object world.

Countertransference Activation

If the therapist's CTRs are not modulated and worked through in personal therapy or supervision, a phenomenon we call *countertransference activation* may result. Countertransference activation is described here as the therapist breaking the frame of therapy in the service of his or her own countertransference feelings of protectiveness and security. This is an important CTR that we have observed in our own work with traumatized patients as well as in our supervision and consultation with colleagues. Countertransference activation is most likely to be an issue in work with individuals who appear to be directly threatened by a perpetrator in their current lives. For example, patients with a reported history of cult abuse who describe ongoing harassment and threats by cult members may activate powerful affective reactions on the part of the therapist. These CTRs may include strong maternal/paternal feelings of overprotectiveness, rescue fantasies, and intense fears about the patient's safety. One danger of unmonitored countertransference activation is that it compels the therapist to break the frame of therapy by becoming too active and overinvolved in the patient's dilemma as opposed to being reflective and empathic with the patient's experience of being in danger.

Case Example Nine

A patient reported being harassed by telephone on a daily basis by cult members. This patient told her therapist that a "cult-created alter personality" was in danger of returning to the cult. These telephone calls, which presumably came in the middle of the night, were believed by the patient to be activating "programming" to return to the cult. The patient was overwhelmed by fear and terror because of her belief that she would be killed if she returned to the cult. The therapist consulted one of the authors of this paper after she had become "stuck" in her work with the patient. The therapist reported feeling fearful, distressed, helpless, and overwhelmed. She felt responsible for the patient's safety. She reported several experiences that represented a breakdown in boundaries between she and the patient. For example, the therapist agreed to be "on-call" 24 hours a day for crisis calls. Many of these calls occurred in the middle of the night and involved prolonged conversations in which the therapist tried to convince the various alter personalities not to respond to the cult

members. On one occasion, the therapist agreed to meet the patient at her office late at night because the patient reported that she was in immediate danger of leaving her house and meeting with a cult member. The therapist was exhausted, depleted, and "burned out" in her work with this patient and was on the verge of terminating the therapeutic work.

The above case, although extreme, is not an uncommon example of Type II countertransference activation gone awry in therapists who work with patients who perceive themselves to be in danger. The powerful pulls on the therapist to be actively nurturing, helpful, supportive, and so forth impose an important therapeutic dilemma that needs to be openly addressed in the professional community. Too often, therapists may become overextended before they seek supervision and consultation because initially these responses appear to be supportive and helpful to the patient. Once overextended, therapists may feel ashamed at their overinvolvement with the case and thus avoid consultation for fear of their colleagues' disapproval. These types of countertransference dilemmas emphasize the need for ongoing supervision and support in working with these complex, difficult cases.

Clinical Case Analysis of Countertransference and Vicarious Traumatization

The following segment of a transcript is from a session with a female patient who reported severe early childhood trauma. The transcript will be explicated in terms of the hermeneutic conceptualization of countertransference, empathy, and understanding as described above. This transcript demonstrates how the case material produced intense CTRs and vicarious traumatization on the part of the therapist, which needed to be continually monitored in order to maintain effective empathy. Those shifts in empathy due to CTRs and vicarious traumatization will be highlighted.

The patient was a 27-year-old single woman who worked as a clerk in a department store. She had been in weekly psychotherapy with the first author of this chapter (ILM) for approximately 6 weeks. The patient had not been in treatment prior to the present time. For the first few sessions it was difficult to believe that the patient was even emotionally present. The patient came into the initial session in an extremely traumatized, regressed, frightened state. The patient was brought to the session by a friend who spoke for her. This woman shared pertinent aspects of the patient's history. Early on it was learned that the patient had regressed

significantly over the past year as memories of severe, ritualistic childhood abuse began to emerge, and there was evidence of fragmented internal parts. The patient had been sadistically and ritually abused by her father from age 4 through 16, when the patient moved out of the house to live with an older, male friend of the family. It was not yet known whether this man had also used and exploited her sexually but it was known that the patient had been in a series of horrifying, abusive relationships with men over the course of her adult life. The patient had no previous therapy experience but had been in pastoral counseling at her church. Her friends now appeared to be in over their heads and had finally "insisted" that the patient be referred for psychotherapy. At the sixth session the patient presented herself in a childlike, regressed fashion She spoke in a childish, "sing-song" voice and sat curled up in a fetal position throughout the session. The annotated remarks include the therapist's comments on her CTRs throughout this session.

[I was aware of strong countertransference reactions as soon as I saw the patient sitting in the waiting room that day. Believing that the patient's father sexually, physically, and emotionally tortured and tormented her in a ritualistic way, I was aware of feeling enraged at what her father did to this child. I was aware that I blamed him for her current childlike, regressed, traumatized condition. I was also aware of maternal, protective feelings toward her, intermingled with rage. I felt like a mother lioness who is protecting her young.]

PATIENT: My daddy is coming home and he wants to see me. I told mommy I didn't want to see him. He said he was going to come up when I visit. I haven't seen him for 16 years.

THERAPIST (*gently*): I don't think it's a good idea for you to see him now.

P: One time he called and talked to me. He scared me. He threatened to come and get me.

T: He scared you very much. I don't think it's safe to see him now.

[I was aware of needing to step in quickly to provide support and containment. I was also aware of needing to lend her my ego. I was frightened for her and intensely aware of her extreme vulnerability. She seemed so childlike and unable to defend herself.]

P (*childlike voice*): Do you think he might be all better now?

T: No, I don't believe that.

[I was aware that I directly engaged with her here. I wanted to provide direct, realistic support. Somehow it seemed important to directly address the denial and to let her know that I was right there with her.]

P: I can hide my people [alters] inside if he comes.

[The patient clearly did not accept my offer of reality. She was still in denial and somehow I felt that this was dangerous for her now. I continued to feel concern for her safety.]

T: But they may be scared. He hurt you, he raped you. It's too soon to see him.

[Looking back on the transcript, I was surprised at how early I named the abuse in such straightforward language. However, I felt the need to pull her back for fear of her being hurt and possibly threatening our work early on. I was concerned that in her regressed, childlike state the patient could not see the implications of her choices or make appropriately self-protective judgments on her own behalf.]

P (*sing-song, chanting voice*): It's too soon, it's too soon. But he can't hurt you anymore.

T: He can't hurt you in the outside world but he can hurt you in the inside world.

P: I missed you. (*Starts talking gibberish.*) (*sing-song chanting*) You can't be scared, you can't cry, you have to be strong.

T: You can feel the feelings in here. You're safe now.

[I continued to be aware of a pervasive feeling of anger and horror at what this father must have done to this young woman to damage her to this extent. I was enraged and wanted to protect her, to keep her safe; these feelings for me are maternal and nurturing. I did not want her to see her father. I was more active at this point in the session, and I wanted to be clear in my responsibility to her. I felt encouraged that she appeared to be able to begin taking me in, establishing contact. Her statement that she missed me over the previous 2 weeks appeared to indicate the beginning of transference.]

P: (*Begins to vividly relive memory of ritual abuse.*) Blood on the wall. Baby hurts . . . it's dead. Poor baby. Someone killed the baby . . . I have pretty flowers in my bedroom.

[Here, the patient suddenly regurgitated bits of unconnected fragments of trauma. It felt a bit like she was vomiting the material from deep within her. It was gruesome, horrible material and I was aware of feeling sick in my stomach, a similar place as where the material seemed to come from in her. I realized my reaction and felt that I could stay with her through it.]

T: And the flowers comfort you now when you are in pain. It's safe here now. . . . I'm sorry for what happened to your baby.

[This appeared to be an empathic statement. I was trying to "be with her."]

P (*switching into adult voice*): Are you mad at me?

[This seemed to be a transference reaction. I believed that she may have told others in the past and their reaction was to become angry with her. I felt she was needing to test whether I was safe, or would I recapitulate what others had done to her?]

T: Why would you think I am mad at you?

[In rereading the transcript, I believe my reaction to her transference is due more to my own countertransference feelings than an attempt to maintain empathy. I was taken aback by the adult voice and "pulled away" from her momentarily. Asking her a question here did not acknowledge the immediate process but protected me from my own threatening feelings in response to her adult voice.]

P: For talking about my daddy.

T: You're afraid I'll be angry if you talk about him. . . . Your father hurt you. I feel angry at what he did to you when you were little but I'm not angry at you.

[Reacting to my own defensive pulling back from her, I was aware of wanting to say, "He did this to you, not me." I was aware of not wanting to be the object of her negative projections. This is a difficult countertransference reaction for me as it is painful to be experienced as the perpetrator.]

P: He'll kill me, hurt me.

T: If you tell?

[Ah ha, I felt now like I understood. Of course, she was terrified about having made this disclosure to me. She wanted to know whether I would be able to "hold" and "contain" it for her or whether she would be destroyed. I felt like I can stay with her here.]

P: Yes.

T: You're afraid that you told me the secret.

P: Yes. They will kill me. Mister hurt my baby, the knife, oh the knife. See the pretty candles. God will hate me for what I did. . . . (*a sudden shift*) Daddy didn't hurt me. He loved me, he was very good to me.

[The patient could not quite stay with the material. She needed to pull back and retreat to a defensive, primitive denial.]

T: It's painful to face what happened but your father hurt you. It's safe to talk about it now.

[Engaging here, I made an empathic statement acknowledging her pain. I was aware of wanting to give her support for continuing her disclosure. I wanted to validate her experience and somehow reduce the need for the defensive denial.]

P: (*Becomes very scared, starts speaking gibberish.*) The pipes, the pipes, oh my god. (*curled up, crying, reliving*)

[I was alarmed here. Did I come "too close"? I feared that she might move into a psychotic state. Internally, I wanted to say "Come back!" On the other hand, perhaps this was a reaction to my validation and a continuation of abreaction of prior traumatic experience and affects.]

T (*feeling like I had to pull her back, in a strong voice I say*): Try to stay connected to me, in here. You're safe now. When you see the pictures in your mind, try to put words to it.

P: In the basement, Daddy, pipes, tight. I hurt. Chains. Water. (*affect shift*) You be good, you can't cry. Don't say no. Don't tell Mommy.

T: Where was your mother?

[I was aware here of distancing somewhat by asking her a question about the context of the experience. Perhaps I could only take so much at this point.]

P: Home.

T: Does your mother know what happened to you when you were little?

P: Some things.

T: Does she know what your father did to you?

P: Yes, but she doesn't understand me, she doesn't want to believe me. Where was my mommy? She tried to kill herself. If I'm mad at my daddy, will God forgive me? Mommy tells me he's my dad, I should forgive him. Should I forgive him? Is God mad at me because I can't forgive him?

[I was aware again of being very angry and needing to feel the anger and protectiveness that her own mother did not feel for her. I was also outraged at whoever made her feel that God would not forgive her and that she was responsible.]

T: You're very angry at your father. What he did was wrong. You were just a little girl. He hurt you very badly. You still feel all the hurt inside.

P: (*major reliving*) He forced me to take a sleeping pill. Oooooh. My tummy hurts. (*childlike voice*) I didn't mean to go to the bathroom. He put me in the car, in the trunk of the car, and he locked me up. I was a bad girl. Bad girl, bad girl, I have to hurt you now.

[I was aware of feeling sick with the horror of it. She needed me to hear the horror for her. It felt like we were stepping into the abyss. I felt ready now, although one is never really ready. But I felt like I could stay with her. At the same time I felt the horror, I was aware of feelings of tenderness for her. She seemed so young, so vulnerable.]

P: He hurt my tummy, he put his penis in my mouth to teach me to listen. He went to the bathroom in my mouth. He put me on the circle rug and took a knife and made it hot and he stuck it into my tummy.

[My heart felt like it would break with the sadness of it. I thought to myself, "Oh God, it's going to be really bad. This is just the beginning. We've just stepped into the abyss."]

T (*soothing sounds*): It hurts, I know. I'm so sorry he hurt you like that. . . .

P: (*Begins to sob and sob.*)

T: I know, it hurts, you need to let it out, you're safe now.

This case example illustrates the need for continual awareness of and monitoring of countertransference feelings on the part of the therapist. As we have illustrated above, unresolved and unmonitored CTRs can result in either of two experiences for the therapist. Defensively, the therapist may move away from the patient's experience as a result of the empathic strain created by the CTR. Thus, the boundaries between the therapist and the patient may be too impermeable. In this case, the therapist may experience detachment, distance, emotional numbing, intellectualization, and a failure to deeply empathize with and understand the patient's experience. Likewise, as described above, too great an increase in the permeability of boundaries between the therapist and the patient may result in countertransference activation, overinvolvement with the patient's experience, and a breakdown in the frame of therapy. An inability to monitor CTRs, leading to empathic strain, will be experienced unconsciously by the patient and may lead the patient to act out, or to feel abandoned, misunderstood, or violated. In other words, the patient is retraumatized. As depicted in Figure 4.2, the dance of empathy occurs when these reactions are monitored in a way that increases the effective empathic stance toward the patient in which the therapist "moves with," but not too close to, the patient's experience.

Step 3: Monitoring of How CTRs Are Affecting Effective Empathic Stance toward the Patient

There will be an increased level of understanding of the material presented by the patient as the therapist corrects his or her empathic position.

The patient, feeling listened to, understood, and respected within a safely boundaried relationship, will begin to "take in" and ultimately internalize the correct empathy as offered by the therapist. This will often result in greater spontaneity and trust on the part of the patient in which further elaborations and details will be freely offered within the session. The patient will be able to move into areas of his or her experience that were previously too threatening to approach, and greater insight on the part of the patient will emerge.

As the empathic position is corrected through monitoring countertransference feelings, the therapist's understanding of the patient's experience deepens. The permeability in the boundary between the therapist and the patient increases as the therapist comes to understand the complexity of the patient's object world. The quality of the therapeutic relationship is enhanced when the patient feels greater safety, containment, and analytic "holding." In the early phases of therapy, the traumatized patient is often vulnerable, frightened, overwhelmed, and needy. When a patient is acutely traumatized, as in the early phases of therapy or when traumatic material is beginning to emerge, patients may need tools for grounding and safety. Here, education and direct interventions, such as the use of "safe-place" imagery, may be helpful as the patient learns to internalize the empathy of the therapist and develop internal resources for affect tolerance and self-soothing (McCann & Pearlman, 1990a). When the dance of empathy is under way, the patient is able to safely approach threatening material with less anxiety. The patient feels less fear about "telling" or acknowledging what happened. Transference projections begin to be named and understood as recapitulations of earlier, abusive relationships. Now the patient's intolerable or unacceptable affects, wishes, impulses, and traumatic memories are able to be "contained" and thus looked at, "owned," and ultimately worked through. Uncontrolled flashbacks, intrusive ideation, nightmares, flooding, and self-destructive impulses decrease and the patient is better able to regulate the emergence of traumatic material both in and out of the session.

In essence, the patient is able to experience a sense of being "held" and understood. It is important to note that we distinguish analytic "holding" from literal holding. We encourage therapists to never engage in physical touch with patients because of the powerful, conflictual wishes and fantasies that may be activated. Within a broadly psychoanalytic perspective, we believe that patients feel "held" when they feel listened to, respected, and understood within a safely boundaried relationship. Analytic holding is distinct from more direct "nurturing" approaches, such as providing teddy bears, children's toys, and physical holding. One of the dangers of providing direct types of holding is that it encourages regression. We previously described that powerful wishes and fantasies to regress may be activated in the patient as he or she unconsciously seeks to

enact these fantasies within the therapeutic relationship. The therapist may experience a resonance with the patient's experience, resulting in a pull to nurture, protect, support, or otherwise "reparent" the patient. These countertransference fantasies must be continually monitored so that regression is minimized for the patient.

Step 4: Completion of One Cycle of the Hermeneutic Spiral: The "Dance"

The therapist and the patient are now able to coordinate their moves and dance together. The dance of empathy involves a circular, reciprocal process of "being with," or moving closer, to the patient's experience and moving away from the material in order to maintain an appropriate empathic stance and level of understanding. The choreography of the dance is determined by the therapist's awareness and management of the countertransference.

The following transcript is a session in which a patient reflects on her reactions to a previous session in which she acknowledged and abreacted a previously disavowed memory of sexual abuse by a stranger in childhood. The exploration of this memory also activated the patient's fears that she may have been sexually abused by her father as well. Transferentially, this patient had also previously found it extremely difficult to acknowledge any angry or negative feelings toward the therapist, despite the fact that her words and feelings suggested profound ambivalence toward the therapist and difficulty establishing trust. The transcript will be annotated to include comments on the four-step process.

The Dance: Case of a Female with a History of Childhood Sexual Abuse

CLIENT: I'm mad . . . I don't want to talk today (*loud laughter*). (*long pause*)

THERAPIST: You're feeling very angry today.

[Step 1: Listening to the words and feelings]

C: I am. (*sadly*) I wish I could just take all my medicine tonight and get it over with but I can't, I have to work tomorrow.

T: It seems as if it doesn't feel safe to be angry in here.

[Step 1: Listening for the object relations]

C: I don't want to talk about that. (*louder voice, looking down at journal*) (*affect shift, softly*) I wish I could just quit thinking about it.

T: Uh huh.

C: I wish I could just take all my pills, every one . . . (*affect shift, louder*) but I can't do that, (*pause*) it just makes me so mad.

T: Mm.

C: (*long pause*) You know what, (*breaks down crying*) if this really happened, then all this stupid shit with my father must have happened too.

[Step 3: Moving into areas that were previously threatening]

T: It hurts a lot to believe that may have happened.

C: (*long sigh*) I just want to scream, I don't believe it.

T (*soothing*): Tell me about it. . . .

C: (*long sigh*) (*voice cracking with tears*) It goes so far back, that memory, 5 years ago, I had a damn flashback of being in the corner of that room, that winter, that man who put his hands between my legs . . . it's been so many years, it's all a memory, it's just a memory and I don't remember anymore but I think he breathed really funny, and it was really scary, and if that's real, all this other stuff may be (*long sigh*). That really hurts.

T: I know it does. . . .

C: (*long sigh, taking deep breaths*) I don't know what to do about this . . . (*sigh*)

T: You're feeling very hurt but you're also feeling very angry, a lot of confusing feelings today. . . .

[Step 1: Listening to the words and feelings]

C: (*affect shift*) Yeah, but mostly I'm mad at my mom and dad . . . bastard, I wish I could kick him you know where, yeah, I'd like to kick him there a million times until it would hurt bad enough, which supposedly it does. (*long releasing sigh*)

T: And very angry at me as well. . . .

[Step 1: Listening for the transference projections]

C (*blast of angry affect*): Yeah, because you're the one who brought it up . . . (*shift into a softer voice*) but you know, after we talked about the memory in our last session, I felt better, I felt older, and it wasn't bad, it was a good feeling, I wrote that to you, I felt like maybe I didn't have to feel so little next to people, like maybe I could be way up there too, grown up like.

T: Perhaps you've felt that in our relationship, that I'm way up here and you've felt little next to me. . . .

C (*softly*): Yeah, sometimes. . . . I mean you are, you're very wise and very sophisticated . . . and everything like that . . . it's not that you put me

down, you never do, but sometimes that's just the way I feel (*sigh*) but you know, but you know, when we did the memory, it was like it was not so bad, cause I could just walk out of that room, like I was a woman, it's like, I don't know how to say it, but, it's like I was going to say I'm more complete, but I don't know how to explain that, except it's like, I'm more in control . . . before it was like I was a child terrified of these bits and pieces . . . (*strong voice*) but now it's like, I have looked at you, you son of a bitch, and I've seen what you did to the child that I was and I'm an adult and you'll never touch me again . . . and I feel older, I feel more my own age, probably, and I like it.

T: It feels good, feeling more like an adult, more your own age. . . .

C: It feels *very* good, yeah (*sigh*). It's almost like I don't have to be cute and vivacious every damn minute . . . and I know that sometimes, but it's like, it's like inside me, I don't have to be that way at all . . . I can be serious, if I'm tired I can be tired and that's a good feeling, yeah . . . so I guess something good has come out of it already . . . (*pause*) (*in a whisper*) I didn't want to come tonight (*sigh*).

T: Tell me more about that. . . .

[Step 2: Awareness of own CTRs: having previously monitored wish to be idealized by patient, therapist shows a willingness to genuinely listen to patient's conflicted experience within the therapy relationship]

C: Oh, I didn't want to come, I was mad at you, I didn't want to come, I was too tired, I resented having to come . . . but now it's good to talk with you . . . but I just, I wanted to hurt you (*pause*).

[Step 3: Increased insight on part of the patient about transference reaction and its relationship to the abuse]

T: Sure you did, it's understandable that at times you may experience me as your tormentor, bringing up these painful memories. . . .

C: How can you say that, I mean, that's so awful of me (*breaks down crying*), how can I feel that, you're so nice to me.

T: It doesn't mean that you don't also feel furious at me sometimes and that it's safe to talk about it in here. I imagine you may have wanted me to feel some of the hurt . . . to know how bad it feels. . . .

C: (*long sigh*) Yeah, awful. . . .

T: And can I really understand how deeply hurt you have been. . . .

C: Yeah, you can, you do . . . I mean I've wondered if you were abused . . . you've told me why you won't answer that before so you don't have to answer it . . . but you do understand, when you say, I know, and I know that you know and whether it's because of your work with other women or because you know because it happened to you, it doesn't matter, it's like, it feels nice, no nice is a shitty word, I feel comforted. . . .

[Step 4: The dance; patient reports comfort of feeling understood; therapist able to "be with" patient and understand patient's wish to make therapist understand by making the therapist hurt, to feel how deeply tormented patient feels]

This transcript illustrates the circular, reciprocal process of "being with" the patient's experience through listening and awareness and management of the therapist's countertransference. When an effective empathic stance was achieved, the patient was able to more freely acknowledge her ambivalent feelings and begin to work through threatening experiences.

CONCLUSION

As the dance of empathy unfolds and deepens, the patient is gradually able to experience the therapist as "being there" in a safe, constant way. Over time, the traumatized patient will be able to internalize the therapist, first as part object and later as whole object, and thus consolidate internal resources for tolerating and integrating strong, unacceptable affects and impulses. Thus, object constancy and the internalization of safe "whole" objects can begin to occur. This leads to a decrease in symptoms, and it signals the initiation of a therapeutic alliance. Now the patient can tolerate being alone without feeling distressed and anxious. As the patient begins to internalize the therapist as a whole object, the patient becomes less reliant on transitional objects for comfort and care and instead will begin to show an increased capacity for affect tolerance and self-soothing (McCann & Pearlman, 1990a).

In summary, this chapter explored and explained the importance of understanding and managing CTRs with persons who have experienced early childhood trauma. A psychoanalytic and hermeneutic conceptualization of the relationship between empathy, understanding, and countertransference was presented. This conceptual formulation explicates the intricate and complex process by which the therapist maintains a consistent empathic stance with patients who report horrific, vivid memories of childhood abuse. Through self-monitoring and an increased awareness of his or her internal experience within the therapy session, the therapist is able to more carefully modulate and utilize CTRs to "be with," understand, and empathize with the patient's experience. This process is metaphorically conceived of here as a choreographed dance in which the therapist and patient move forward together in a fluid but deliberate pattern of interaction. This "dance of empathy" is guided by the quality and consistency of the empathic responses as determined by the thera-

pist's CTRs. It is from within this empathic position that the traumatized patient's tortured internal experience and object world can be known, understood, respected, and ultimately transformed.

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