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The client-therapist relationship in EMDR psychotherapy

How to address these issues in consultation

13 nov. 2021– EMDR UK Association

The client-therapist relationship in EMDR

Transference and countertransference

Historical background and definitions

Definition – Transference:

« The unconscious repetition in a current relationship of patterns of thoughts, feelings, beliefs, expectations, and responses that originated in important early relationships ».

Pearlman & Saakvitne, 1995, p. 100.

- The patient **transfers** on the therapist his/her own issues originated from early childhood relationships

- **Reenactments** of past traumas in the therapeutic relationship

Freud 1st use of the terme « countertransference » in 1910.

« We have become aware of the 'counter-transference', which arises in him (the therapist) as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it. … we have noticed that no psycho-analyst goes further than his own complexes and internal resistances permit;

And we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his observations on his patients.

Anyone who fails to produce results in self-analysis of this kind may at once give up any idea of being able to treat patients by analysis. »

Freud, *The future prospects of psycho-analytic therapy*, 1910.

Freud's narrow definition of countertransference

- **« The analyst's unconscious, conflict based reactions in response to the patient's transference »**

Hayes (2004)

A broad definition of countertransference by Heimann and Little

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- A definition according to the work of Heimann (1950) and Little (1951)

- **« All therapist reactions to a client, whether conscious or uncouscious, conflict based or reality based, in response to transference or some other material »**

Hayes (2004)

An integrative conceptualization of countertransference Gelso & Hayes (1998)

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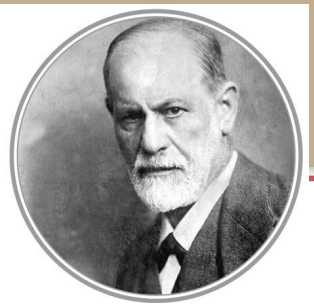
- **« Countertransference is defined as therapist reactions to clients that are based on therapist's unresolved conflicts »**
- « The source of the therapist's reactions as residing **within** the therapist »
- → **responsability of the therapist.**

Hayes (2004)

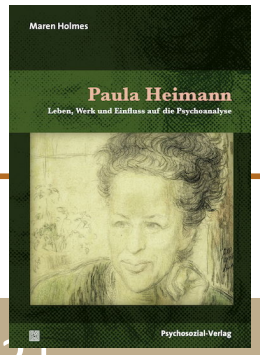
Historical background

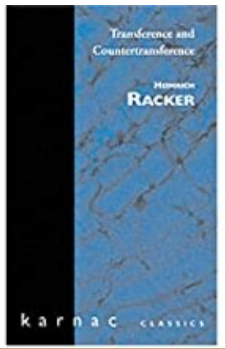


Focus on transference.
Countertransference is a source of problems.
The therapist should be emotionally neutral and like a « mirror ».
Countertransference should be neutralized or overcome.
Strong reaction on the side of the therapist is a sign of pathology.

Sandor Ferenczi

Focus on both transference and countertransference.
Countertransference can be a rich tool to understand the patient and the relationship patient/therapist and for therapeutic interventions.
The therapist cannot be neutral.
The therapist CANNOT not have an unconscious.
End of the myth of the healthy psycho-analyst.





Countertransference and Trauma

Définition: Pearlman & Saakvitne

- **2 components:**

1. The affective , ideational, and physical responses a therapist has to her client, his clinical material, transference, and reenactments, and
2. The therapist's conscious and unconscious defenses against the affects, intrapsychic conflicts, and associations aroused by the former. (Pearlman & Saakvitne, 1995, p. 23)

Most definitions of countertransference include : (Pearlman & Saakvine, 1995)

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1. The therapist's affective response to her client: to client's identity, presentation, material, interpersonal style, history.
2. The therapist's transference to her client, based upon her own history.
3. The therapist's responses to the client's transference to the therapist.
4. The therapist's defenses against her own affects or intrapsychic conflicts aroused by her client and his material in the session.
5. Any responses that hinder a therapist's ability to be therapeutic to her client or impede the therapy.
6. The therapist's unconscious responses to her client.

Factors contributing to counter-transference in trauma therapies

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1. **The therapist's response to the reality of incest and child abuse.**
2. **The therapist's responses to the client's transference**, which will vary with both the nature of the transference and its consistency with her own experience of self.
3. **The therapist's response to the client's particular post-trauma adaptation**, e.g. numbing, flooding, dissociation, intrusive imagery and memories, repression, anxiety, chronic suicidal wishes, depression, despair, interpersonal mistrust, revictimization, self-loathing etc. …/…

(2)

4. **The therapist's history**, personality, coping style, and transference to the client.
5. **The therapist's response to her own vicarious traumatization**
6. **The therapist's theoretical perspective on trauma and relationship to her teachers and mentors in the field**.

(Pearlman & Saakvitne, 1995, p. 24-25)

Countertransference can be used:

- **Intrapersonally**, for the therapist own edification and insight
- **Interpersonally** throught considered counter-transference disclosure, as well as through countertransference-informed exploration of the relationship and the client's experience of the therapist.

Pearlman & Saakvitne, 1995, p.78.

Transference and countertransference:

AIP based definitions

Proposition :
Transference in AIP model

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In the AIP model, transference can be defined as :

- **The activation of dysfunctionally stored (mainly adversity or problematic attachment) memories of the client in relation to the therapy, the clinician, or the relation to the clinician.**

Proposition : Countertransference in AIP model

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In the AIP model, countertransference can be defined as :

- **The activation of a dysfunctionally stored (adversity/attachment) memory of the therapist**
- **By the patient, his history, his material (conscious or unconscious or dissociated).**
- **This can have an effect on the EMDR therapy and on the AI Processing of the patient.**

Transference in EMDR
- choice of therapy
- during processing

Transference and the choice of therapy

- Some patients ask specifically for an EMDR therapy. This may include transferential elements.
- Ex:

(My parents never took time for me, for my needs,)

I want a fast (and technical) **treatment** (because anyway I don't except people to take time for me and listen carefully to what I have to say).

Be aware of a reenactment

- In such a case the therapist should be careful because if he uses EMDR without noticing the relational issue, he/she will re-traumatize the patient and confirm his/her relational shema that could include such a NC:
- « I do not deserve that people show any interest in me » or
- « I do not deserve love »

- When a client requests an EMDR therapy, based on a transferential issue implying a trauma reenactment
- This can collude with a therapist's countertransference issue.

→ Be aware of a blocking !

Exemples

- When the therapist needs to feel **mastery** and a feeling of **efficacy**.
- When the therapist needs to avoid the client's trauma: go through the abuse as fast as possible (**avoidance** - neglect).

- We should consider that **the reasons for which any client seeks therapy has to do with relational issues**. The therapist must therefor be careful and not follow with blind eyes the request of some clients.
- We should also assess relational issues and their possible implications in the therapeutic relationship and in the choice of EMDR by the client.

Transference during the EMDR processing

The patient transfers on the therapist or on the method

about EMDR or during EMDR processing

his/her own issues.

- I will never make it.
- I cannot succeed
- If I don't do well, you will be upset
- I am not worthy
- I have no right to happiness
- I have no right to live
- I have no right to complain
- One should not show any emotion

Summary

1. Empathy or basic information on EMDR or additional information can support the client and help him believe that reprocessing is possible for him, because this is a psychobiological innate process.
2. Standard target sequence plan to reprocess and neutralize the schema that blocks therapy.
3. Postpone EMDR.

Countertransference in EMDR

Proposition

- Like in other therapies,
- The attention on the countertransference can avoid impasses, even retraumatization of the patient and of the therapist, and
- The use of countertransference can unblock the therapeutic process also in EMDR (release the AI Processing)

Factors contributing to counter-transference in trauma therapies

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(Pearlman & Saakvitne, 1995, p. 24-25)

Countertransference in Phases 1 and 2

Major traps for the therapy

To avoid some unresolved trauma material the therapist decides

- to do EMDR (phases 3-4-5-6) to soon or
- to do EMDR later than is safely possible.

Case study : Eric, 36 y.

- Sexual abuse at age 3-4 from a mentally retarded 17 y. old adolescent.
- Sexual difficulties
- Relational difficulties with women; no girl-friend
- Well adjusted in work and in social life
- Supportive family and friends
- “I have a very deep lack of love and affection ”
- “I wanted to help myself on my own, but it doesn’t work anymore”

Therapy of Eric - 1

- 9 sessions of phases 1 and 2

  → Diagn: not too complex traumatization

  → Proposition of treatment: EMDR

- 8 sessions of EMDR on the sexual abuse

  →SUD 1-2

Therapy of Eric - 2

- **Telephone**: *not well, fear of being paedophile, activation of new elements of the trauma*
- 4 sessions: investigation – measures of safety and stabilization
- 12 sessions ego state therapy & hypno-imaginative exercises → Blocking
- **Supervision** to resolve the impasse

Eric's therapy

Phases 1 and 2

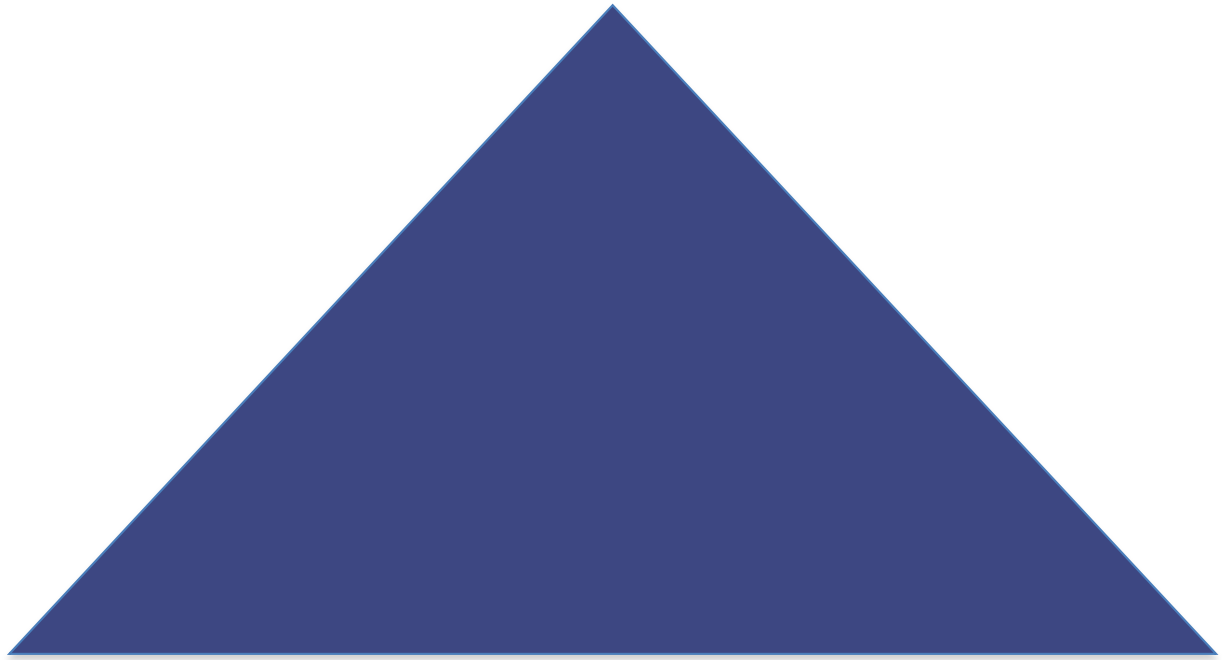
- 9 sessions of investigation and stabilization

  → Diagn: not too complex traumatisation
  → EMDR

Countertransference

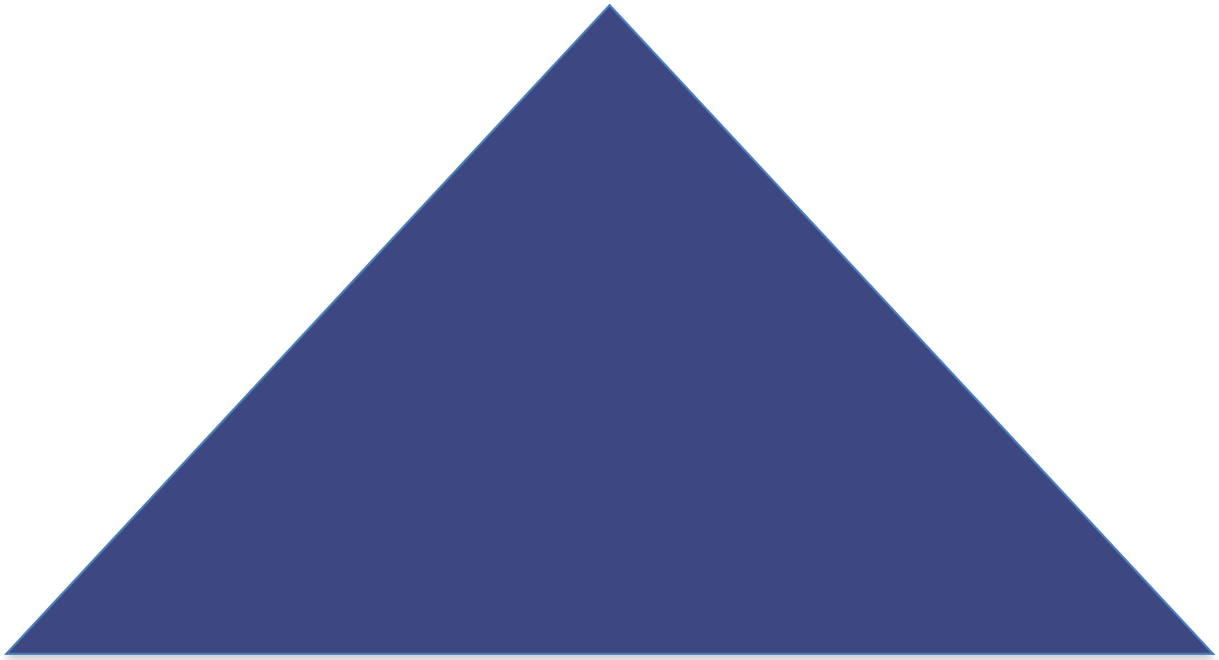
- Irritated by the attitude of the patient making sessions last longer
- → activation of therapist's relational issue : Feeling being used and controlled in the relationship like with the therapist's mother.
- Somewhat surprised by such sequelas for "only 2 abuses"
- Reenacting the neglect of the parents

Trauma triangle



Trauma triangle

Abused child



Perpetrator

Technically good
but neglecting parent(s)

Eric's therapy

Phases 3 and 4

- 8 EMDR sessions on the sexual abuse

Countertransference

- At the same moment, the therapist is working in his own therapy on a past sexual trauma
- Therapist sees fotos of sexual abuse on children at a conference → traumatization
- Tendency of avoidance
- Not enought supportive with the patient during EMDR

Eric's therapy	Countertransference
Back to phase 1 & 2 Stabilization • **Telephone***: not well, fear of being paedophile* • 4 sessions: investigation – measures of safety – stabilization • 12 sessions Ego state & hypno-imaginative exercises → Blocking	• Same issues as before • Therapist's other own issues also activated. • Therapist feels lost in the Ego state work, althought he knows it well

Eric's therapy

Countertransference

Consultation

- Realization that therapist does bad work with ego state
- Attachment issue of the patient (**neglect** after trauma) became clear and is given its due role in the psycho-pathology of the patient
- Issues of the therapist involved with this patient became clear

Eric's therapy

- Patient accepts to let the therapist take some lead, learning to let go and cooperate with another person (in psychotherapy)
- Therapist is more present in the therapeutic work and gives a better support to the patient
- The therapy includes the relational issue
- Therapy (including EMDR sometimes) works better.

Countertransference

- Therapist feels more freedom and space in the therapy
- Therapist dares address the controlling tendencies of the patient in the therapy and proposes that the patient lets him take some suitable adjusted lead in the therapy.
- Therapist develops empathy /compassion towards the client
- The therapist can now use his own trauma activations when they arise during session.

Case study from consultation

- Experienced psychodynamically trained therapist and experienced EMDR practitioner
- Problem brought in consultation :

  « the patient dissociates during phase 4 »

  = he shows no emotion

Exploration

- Patient demanded to do EMDR quickly and for a few sessions only.
- Emigrated in Switzerland with parents from a former soviet country before 1988.
- Physical violence from father and humiliation
- Complex PTSD & other disorders (OCD, etc.)
- Therapist obeyed and didn’t dare say that this will not be possible
- Therapist is surprised that he came back to the next session. …..

Further exploration

- Therapist realizes that the patient comes from the same region than her mother.
- The experience of humiliation of the client brings up memories of the therapist's mother's experiences of humiliation during WW2.
- Therapist realizes that she is activated as well .
- Therapist did phase 3-4 at the 2nd session !

Countertransference in phases 3 - 7

Clinical vignette

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Childhood sexual violence

NC: I am in danger

- I feel unsafe. (BLS).
- I feel unsafe and I'm trembling. (BLS).
- Still unsafe, very much so. (BLS).
- I was never safe, never. (BLS).
- I will never be safe.

What to do next ??

Clinical vignette

Childhood sexual violence (continued)

Possible interweave

- Are you safe now?
- What if the child could defend herself?
- What did the child need to feel safe?
- How is it to feel unsafe for so long?
- …..

Use of countertransference during phase 4 (mostly)

- Use information **within the clinician** to unblock the AI Processing, if needed
- Activation of mirror neurons?

– Sensations
– Images
– Thoughts
– Emotions

Relational interweave (Dworkin)

- « A relational interweave is called for when a state-dependent memory has been activated in the clinician, is noticed by the client on some level, and appears to have temporarily stalled the work. »

Dworkin (2005, p. 170)

Relational interweave (Dworkin)

- Block in the processing during phase 4
- Arise within the clinician a similar situation for which he is not congruent with the client.
- Relational interweave, then cognitive interweave
- Release of the client's processing.

Relational interweave – procedure
(Dworkin)

1. The therapist uses himself (and his body) as a barometer of interpersonal interaction.
2. The clinician becomes aware of the reciprocal mutual influence between the client and himself.
3. The clinician notes his contribution to the block in processing.
4. The clinician crafts an intervention throught which he takes rational responsability for his own reaction to the client.

Example

- Target : situation at work with the boss
- Blocking : anger against the boss
- The therapist realizes that he himself does not want to let go his own anger against his former boss.
- Interweave : » I understand your difficulty to let go the anger against your boss. I have the same difficulty in a similar situation. »

Countertransference based interweave

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- After a set of BS, if the patient says that he has no material but the therapist has some material concerning the patient (images, thoughts, emotions, sensations)
- **Hypothesis** : **the therapist receives (thought mirror neurons?) from the patient information that the patient is dissociated from, and the AI Processing is blocked.**

Example : The therapist feels something in his mouth since several sets of SB and the patient reports nothing at that level between SB.

Possible interweaves:

- « How is it in your mouth? »
- « Do you maybe have some sort of sensations in your mouth? »

Case study : X

- Abreaction doesn't come out – long lasting block – different ways to unblock have no success.
- Therapist feels to take the patient in his arms
- Understanding of this sensation/interprétation
- **Interweave**:

➢ « Could it be that the little boy needed to be taken in the arms ? »

- Yes ! (abreaction comes out finally)

Case study: V.

- Therapist falls asleep during EM !!
- Therapist feels uncomfortable after the session and does BS on himself
- A trauma situation comes up strongly
- (partial) EMDR treatment on this situation
- Therapist discusses with the patient and understands that his sleepiness is also a sign of depersonalization of the patient and of the blocking of AIP (below the window of tolerance)

Countertransference can be used:

Pearlman & Saakvitne, 1995, p.78. & Piedfort-Marin

- **Intrapersonally**, for the therapist own edification and insight

  →**case conceptualization, building an alliance**

  →**countertransference-based interweave**

- **Interpersonally** throught considered counter-transference disclosure**,**

  → **relational interweave**

  as well as through countertransference-informed exploration of the relationship and the client's experience of the therapist.

  →**case conceptualization, building an alliance, stabilization**

Personal implications for EMDR therapists working with trauma clients

EMDR therapists need

- Tolerance to intensity
- Tolerance to the intensity of affect
- Tolerance to horror
- Tolerance to the uncertainty / the unknown

- Vicarious traumatization
- Secundary traumatization → PTSD
- Compassion fatigue
- Activation of own traumas/issues

DSM-5 – criteria A

- **Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse).**

Vicarious Traumatization

- The transformation of the therapist's beliefs about therapy, life, the human being, etc.,
- Transformation occurring through the challenging work with severely traumatized individuals.

- Pearlman and Saakvitne (1995)

Proposition

Consider possible :

- Unresolved traumas,
- Not fully resolved traumas,
- Unresolved or not fully resolved issues or inner conflicts

This may appear in theoretical believes

Tools helpful to analyse the therapeutic relationship with traumatized patients

CT and the choice of a method

Clinicians should be aware of such questions :

- Why did I chose to train in EMDR?
- Why do I chose to do EMDR with this patient? And why not with this other patient?
- Why do I accept to do EMDR with this patient demanding an EMDR therapy? Or why do I refuse?
- Why do I need to follow precisely the protocol?
- Why can’t I stop myself from changing the standard protocol ?

During the EMDR therapy and mostly during phases 3-4 etc.

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Stay aware of your / help supervisees to be aware of their :

- ✓ Emotions,
- ✓ Feelings,
- ✓ Images,
- ✓ Thoughts,
- ✓ Sensorimotor reactions,
- ✓ Fantasies.

Flight / avoidance

Hypervigilance

Fight

Recovery

Feint death

Submission


Succoli

Which action system is activated in you?

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- ❑ Hypervigilance
- ❑ Fight
- ❑ Avoidance / Flight
- ❑ Submission / Freeze

- ❑ Attachment cry
- ❑ Care-needing

- ❑ Care-giving
- ❑ Soothing
- ❑ Cooperation
- ❑ Exploration
- ❑ Social engagement
- ❑ Social dominance
- ❑ Attachment
- ❑ Play

Developp an internal observer

- more distance from what we feel
- make a better use of our own feelings and reactivations.

- **Your “small” or resolved traumas might have suddenly a high SUD when you connect with a patient with a trauma on a similar topic of higher intensity.**

Use EMDR procedures with supervisees

- When you have that image of this difficult moment in that session, etc….. (Phase 3)

- When you are in contact with this strange feeling you had during the session with your client, etc… (Affect bridge)

Davies & Frawley :
8 relational positions with 4 matrices

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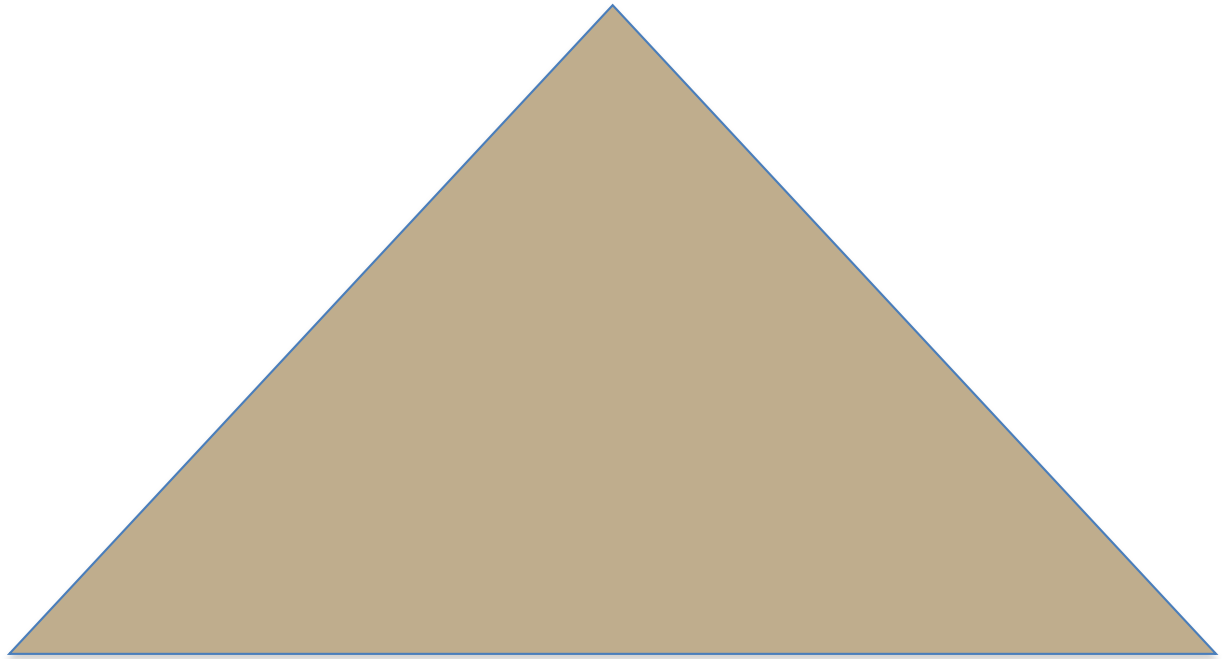
1. The uninvolved nonabusing parent and the neglected child
2. The sadistic abuser and the helpless, impotently enraged victim
3. The idealized, omnipotent rescuer and the entitled child who demands to be rescued
4. The seducer and the seduced

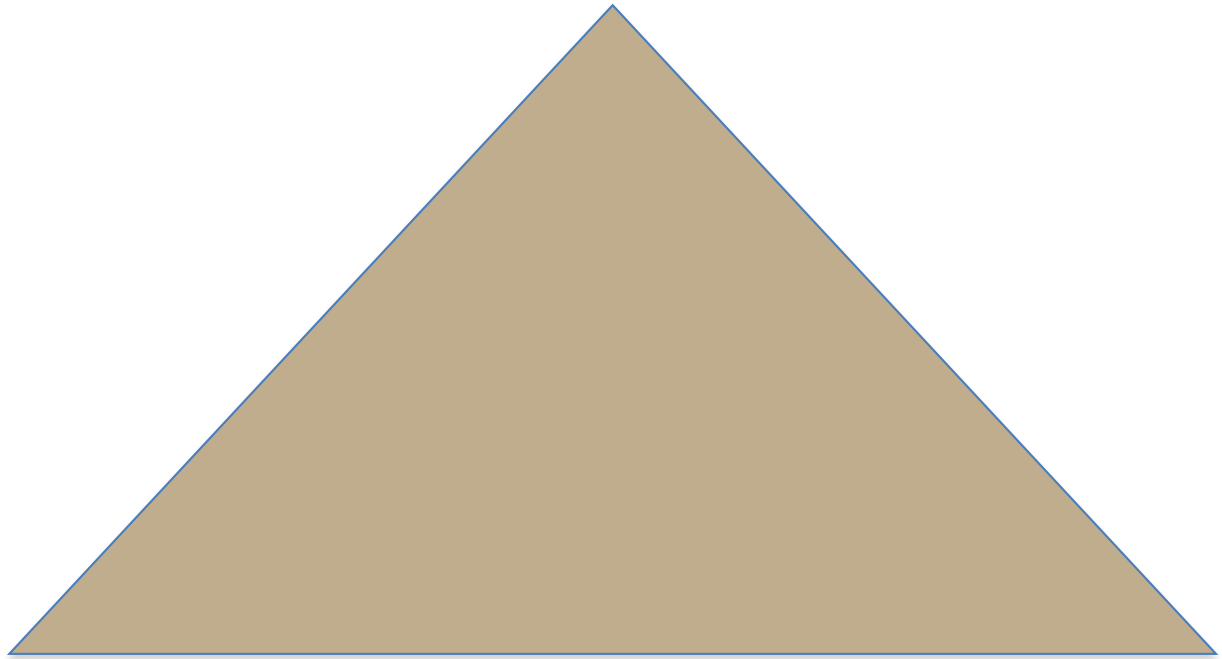
Davies & Frawley (1994)

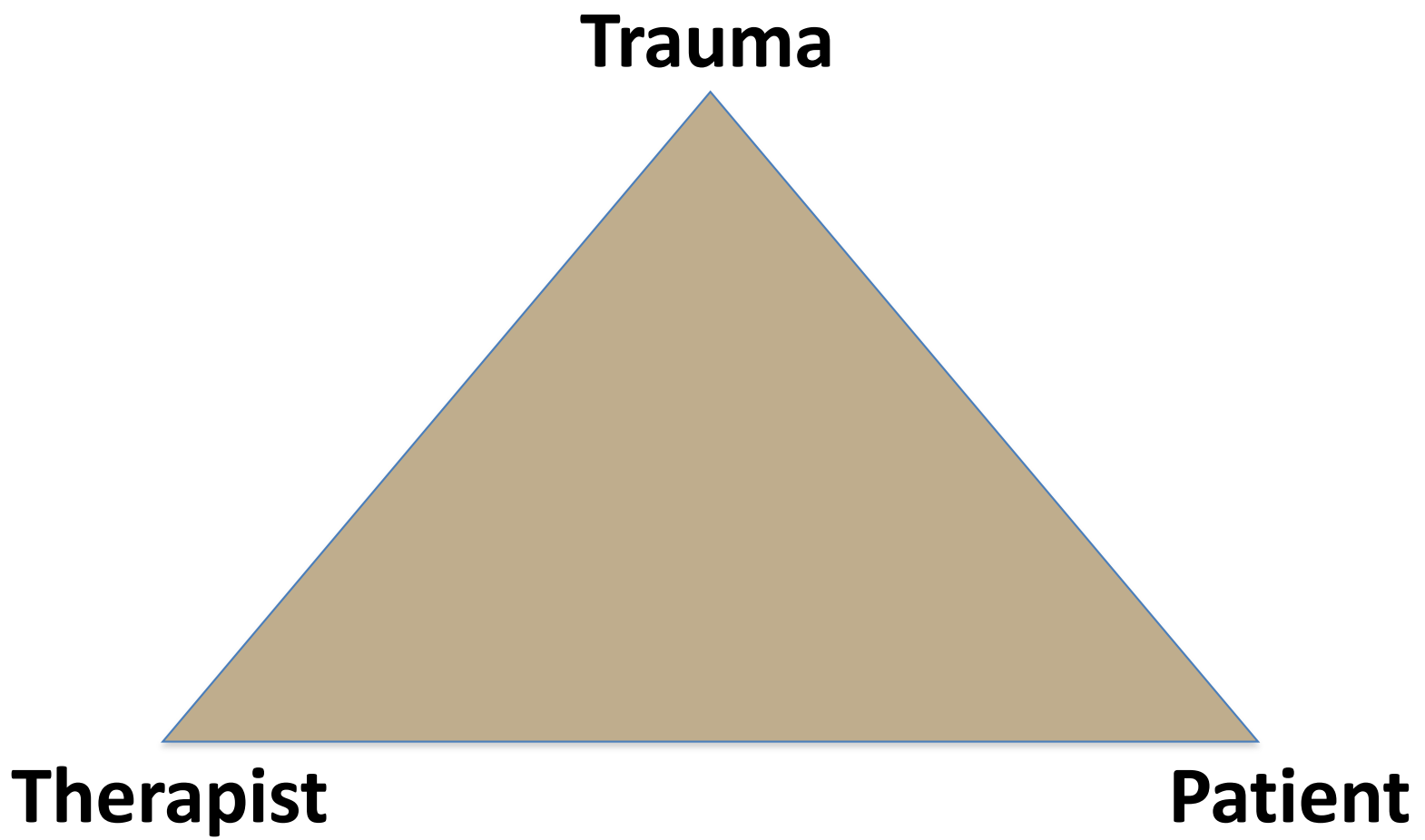
Denial ---------- Fascination

Trauma Triangle



Trauma Triangle - 2




Trauma
Therapist
Patient


Thank you !

References

Dworkin, M. (2005). *EMDR and the relational imperative*. New York: Routledge.

Pearlman L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist. Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton.

Gallese, V. (2009). Mirror neurons, embodied simulation, and the neural basis for social identication. *Psychoanalytic Dialogues, 19*, 519–536.

Gallese, V. (2014). Bodily selves in relation: embodied simulation as second-person perspective on intersubjectivity. *Philosophical Transactions of the Royal Society 369*: 20130177. http://dx.doi.org/10.1098/rstb.2013.0177

Gelso, C., & Hayes, J. (1998). The psychotherapy relationship. New York: Wiley.

Hayes, J. (2004). The inner world of the psychotherapist: A program of research on countertransference. *Psychotherapy Res., 14(1)*, 21-36.

Heiman, P. (1950). On countertransference. *International Journal of Psychoanalysis, 31*, 81-84.

Racker, H. (1957). The Meanings and Uses of Countertransference. *Psychoanalitical Quaterly*, *26*, 303-357.

Racker, H. (1968). *Transference and countertransference*. London : The Hogarth Press.

Van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The Haunted Self. Structural dissociation and the treatment of chronic traumatization*. New York : Norton.

Piedfort-Marin, O. (2018). Transference and countertransference in EMDR therapy. *Journal of EMDR Practice and Research, 12-3*, 158-172.

Piedfort-Marin, O. (2019). Synthesis and realization (personification and presentification): the psychological process of integration of traumatic memories in EMDR psychotherapy. *Journal of EMDR Practice and Research, 13-1,* 75-87.

Piedfort-Marin, O. (2019). When the therapist's trauma emerge in a psychotherapy session: the use of trauma related countertransference. *European Journal of Trauma and Dissociation, 3, 181-189.*

Mirror Neurons System

Embodied Simulation Theory

Gallese (2009, 2014)

- Developed the embodied simulation theory to explain underlying mechanisms of the MNS.
- If we take the example of disgust, it can be modelized that the observer is (unconsciously) ‘simulating’ the feeling of disgust experienced by the person he observes.
- According to Gallese, this simulation is meant to be embodied.

- Embodied simulation is then an underlying mechanism which “mediates our capacity to share the meaning of actions, intentions, feelings, and emotions with others, thus grounding our identification with connectedness to others” (Gallese, 2009, p.524).

- Gallese (2009, p.521) posits that the mirror neurons' activities does not implies a sole visual description of the observed action made by another individual but "reflects an internal motor description of the perceived action's meaning".

- The observer must relate to an “internal motor knowledge” to give a meaning to the observed action of others. Indeed perceiving a person’s action activates neural networks implied in motor action and not merely neural networks implied in perception.

- **This may imply an - at least rudimentary - pre-given internal motor knowledge that may be implicit and prelinguistic** (Gallese, 2009).

- MNS is related to an innate tendency to social connectedness it also enables and that develops through the development of the infant and child.
- Gallese (2009, p. 530) summarizes his model, stating that “we-ness and intersubjectivity ontologically ground the human condition, in which reciprocity foundationally defines human existence”.

- Intersubjectivity is viewed by Gallese (2009, p. 523) “first and foremost as intercorporeity – the mutual resonance of intentionally meaningful sensori-motor behaviors”.
- That is, intersubjectivity is not seen merely a cognitive process but relies on sensori-motor actions. It is seen as a profound body-centered process since the self develops first of all as a bodily self (Gallese, 2014).

- According to Gallese (2009), “the notions of projective identification and the interpersonal dynamic related to transference and countertransference can be viewed as instantiations of the implicit and prelinguistic mechanisms of the embodied simulation-driven mirroring mechanisms.”

What are the neurophysiological mechanisms related to trauma related countertransference?

- We propose that the pre-given often implicit prelinguistic internal motor knowledge (i.e. specific neural networks) of the therapist activates in presence of the patient through his or her verbal expressions, para-verbal components, emotions, physical motions, etc. When they are discreet, such elements may occur out of the conscious awareness of the therapist.

- In this context, **trauma related neural networks of the therapist might be activated, either parallelly or directly, since traumatic experiences of the therapist are indeed pre-given knowledge with a strong bodily component**.
- This gives ground to our hypothesis that **trauma related countertransference should be seen foremost as the activation in the therapist of personal experiences which emerge in contact with the patient and his or her trauma related material.**

- These experiences of the therapist may not always be highly traumatic, but may still hinder the therapeutic process, for example by activating defenses on the side of the therapist.