Countertransference and Related Experiences of Psychologists Serving Suicidal Patients:

Implications for Training and Supervision

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DEDICATION

For my loving wife, Shirley, my parents, Pat and Maria, my sister Rose, my brother John, and my dear companions Bon, Bianca, Anna and Nene.

"This is a narrative of very heavy duty proportions..."

Dr. Teeth, "The Muppet Movie"

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Also, I express my appreciation to over three hundred and sixty psychologists across the nation who took the time to openly disclose their reactions, experiences, thoughts and wisdom regarding their work with suicidal clients.

I also extend my warmest gratitude to the exceptional individuals who contributed to my growth as a person and a professional: Errol Leifer PhD, Susan Orovitz PhD,

Kathy Sullivan PhD, Marie Tomeo PhD, Paul Gardecki, Keith Lyons, and the many others who offered the wisdom and courage to glance further than I ever thought possible. To approach the appropriate expression of thanks due to them would necessitate increasing the volume of this dissertation beyond the capacity of our humble library. Allow me to spare the backs of our librarians and suffice to say, Thank You.

Finally, let it be said that those who take on the challenge of working with those whose lives hang in the balance of intrapsychic ambivalence deserve the utmost recognition for the burden they undertake. Societal and professional expectations have been laid down that place the responsibility of life and death into their hands, regardless of their capacity to determine either outcome. These men and women risk personal and professional outcast through an arbitrary and misinformed judicial process that hastily casts blame with neither rhyme nor reason. Out of contradiction, misshaped roles, and whimsically constructed ideals has emerged a series of phenomena that rest not so subtly on their shoulders. To you, my colleagues, I say continue to fight your good fight and “rage, rage, against the dying of the light.”

ABSTRACT OF THE DISSERTATION

Countertransference and Related Experiences of Psychologists Serving Suicidal Patients: Implications for Training and Supervision

by

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1999

This study examined countertransference and other experiences of therapists serving suicidal patients. A survey was constructed to assess for aversion, narcissistic injury and similar iatrogenic constructs. Participants offered both Likert scale responses and spontaneous unstructured comments. Likert data were analyzed quantitatively. Content and phenomenological analyses were applied to the comments. The findings suggest that a substantial number of therapists treating suicidal patients experience negative countertransferences. The implications for training, treatment and supervision are discussed.

TABLE OF CONTENTS

Chapter Page

Chapter Page

Chapter Page

Chapter Page

Chapter Page

Page

LIST OF TABLES

"During those months I didn't really hate you. I just hated everything you stood for--insight, care and hope." --"Sarah" (Gorney, 1979, p. 322).

Chapter 1

INTRODUCTION

This study seeks to explore the personal reactions and experiences of therapists who work with moderately to highly suicidal patients. The cognitive, affective, and behavioral reactions of therapists will be examined as aspects of the countertransference with special attention to projective identification.

A working definition of countertransference has been offered by Slackter (1987). After an extensive review of the widely ranging uses of the term, he writes that

> Countertransference concerns those personalized emotional responses each analyst makes to a broad range of individual patients in a wide variety of situations during various phases of treatment. While in themselves neither inherently positive nor negative, these responses can promote or hinder the therapeutic process, and it is from this effect that they derive their value, and ultimately their meaningfulness.

Such meaningfulness can hardly be overstated in terms of treatment efficacy, especially in regards to the treatment of the highly suicidal patient. These internal, personal, and affect-laden experiences have the capacity to propel or destroy the therapeutic alliance (Slackter, 1987).

Therapists, given their training, and the very nature of true human empathy cannot avoid entanglement with the powerful and moving world of patients whose lives are in the balance (Maltsberger, 1994). At times the therapist's cognitive, affective, and behavioral experience will elicit an iatrogenic reaction toward clients that may exacerbate suicidality (Maltsberger, 1994).

Explanations for suicide include that it can serve as an act of violent retaliation, a desperate plea for help, or a final resolution to hopelessness (Beck, Kovacs, & Weissman, 1975; Maltsberger, 1994). Each involves a fantasy of interpersonal interaction highly charged with elements of intimacy, rage, and abandonment. The patient who threatens suicide sets the context for an involved, and intense, patient-therapist interpersonal reaction. Naturally, therapists are inclined to assume a defensive stance once they have considered the possible consequences should the patient commit suicide while under their care.

As Olin (1976) remarked, the therapist is in a delicate balance of confirming the suicidal patient's responsibility without being rejecting or rescuing toward him or her. The therapist's capacity to maintain this balance is influenced in part by the manner in which the therapist manages countertransference (Maltsberger, 1994; Olin, 1976).

Of particular interest in this study is a specific type of countertransference, which is the therapist's use of introjective identification in response to a patient's use of projective identification. Projective identification is a process by which the patient projects an aspect of the self or its objects (Scharff, 1992). More simply, patients project an aspect of themselves upon the therapist and via unconscious processes manipulate the therapist to act in concordance with the projection. Through projective identification, the suicidal patient induces the clinician to play the roles of rescuer, abandoner, and even sadist (Flarsheim, 1975; Gorkin, 1987; Jensen & Petty, 1958; Maltsberger, 1994). Introjective identification is the process by which the therapist identifies with the projected part of the patient and subsequently introjects it (Scharff, 1992).

How the therapist manages the patient's projected material often has direct and significant implications for efficacy of the treatment (Ogden, 1979; Scharff, 1992). For example, in one study, which is later reviewed, 6% of cases in which a patient committed suicide involved clear and substantial therapeutic errors that stemmed from therapist behaviors related to negative countertransferences (Modestin, 1987). The implications are that if the treating

therapists had been more closely attuned to their own countertransference they would not have made such serious treatment errors (Modestin, 1987).

It is the aspiration of this dissertation to illustrate the common countertransference experiences therapists report when working with suicidal patients. At present, the literature lacks collected self-disclosures and what exists is theory based on case studies, individual self-reports, and anecdotal evidence.

This study collects anonymous therapist self-disclosures regarding the cognitive, affective, and behavioral experiences they had while working with suicidal patients. Additionally, this study explores how the personal reactions and experiences therapists report compare with the existing literature. Such research may aid in continued theory development and offer practical information to therapists and supervisors on understanding the commonalties of the countertransferences toward suicidal patients.

Chapter 2

LITERATURE REVIEW

Introduction

This literature review will offer an in-depth exploration of the countertransference experiences of therapists treating suicidal patients. Foremost to be considered is the conscious risk the therapist assumes in entering the treatment arrangement. Inherent to accepting the suicidal patient into therapy are several personal, professional, and legal risks. Following this will be a discussion of the concepts of projective and introjective identification in relation to the treatment of the suicidal patient. Implications for therapist training, case management, and supervision are discussed.

The specific countertransference experiences that therapists have reported when treating suicidal patients are examined. These include rescuing-behaviors, hate, aversion, avoidance, and multiple other reactions. The therapist's specific countertransference and the associated patient intra-psychic and behavioral patterns are then explored. The effect of introjective identification upon the therapist is studied, particularly in regard to the concept that performing psychoanalysis is suicidogenic. The therapist's

use of countertransference is explored in terms of potential for diagnosis and various therapeutic techniques. Case management issues including in-patient staff management, consultation, therapist self-care, burnout stress, and the legal implications of negative therapist behaviors based upon unexamined or unresolved countertransference matters are also discussed.

It has been written that "death is the ongoing enemy of the physician," and though the physician may postpone death, he may never stop it altogether (Schwartz, Flinn, & Slawson, 1979). From the outset lies a particular challenge when the agents of death are suicidal impulses within the patient. Making the matter worse, the unconscious, which stirs such impulses, may be oblivious to the threat of suicidality. This perspective was taken by Freud when he wrote that "Our unconscious . . . does not believe in its own death; it behaves as if it were immortal . . . there is nothing instinctual in us which responds to a belief in death" (Freud, 1961c, p. 288).

Before exploring the literature regarding the treatment of the suicidal patient, a brief exploration of the definition and degrees of suicidality will be offered. In 1897, Emile Durkheim defined suicide as "all cases of death resulting directly or indirectly from a positive or negative