COUNTER-TRANSFERENCE PROBLEMS INSIDE THE GROUP OF RELATIVES BEREAVING SUICIDE

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ABSTRACT

Counter-transference is a phenomenon that applies for all psychotherapeutic approaches. It was mostly developed and understood in the psychoanalytical schools of therapy, but applies also for the work in the group of relatives, bereaving suicide of a kin. The authors try to focus on the clinical material from their therapeutic practice, the problems and blind spots from the field that might obstruct the efficient work with these patients if not strictly supervised.

INTRODUCTION

The term countertransference was first mentioned by S. Freud in 1910 (Yalom, 1985). He described it as the patient's influence on the therapist's unconscious processes, which he can recognize and analyse only to the limit of his own inner conflicts and defenses. Counter-transference influences the therapist's understanding or non-understanding of the patient's problems, as the patient represents the object from the therapist's past in which he projects his early experience.

As we can see it now, counter-transference is always influenced by both subjective and objective factors, subjective being the following:

- situational factors :

a/ direct predisposition: sex, age, race, family structure of the patient;

b/ indirect: deriving from the therapist's emotional attitude towards the referral subject (institution, junior or senior colleague, boss, friends, somebody with power)

* transference reactions activated by the patient
* characterological traits of the therapist (personality)

- and objective factors:

* conscious,
* unconscious,
* irrational reactions, elicited by the patient.

Counter-transference in the group is difficult to recognize, because the influence on the therapist has more facets: the transference reactions are going on between the patients and the therapist, between the patients themselves and between the group as a whole and the individual member inside it.

Besides counter-transference there is another similar term - empathy - that covers a broader horizon of therapist's emotional reactions. Comparing both, the major difference would be that empathy is derived from the conscious, non-conflict part of the therapist's personality, while counter-transference comes out of the unconscious and conflict elements.

SUICIDE SURVIVORS GROUPS AND COUNTER-TRANSFERENCE

When leading analytically oriented groups of patients, the therapist reveals, analyzes and interprets transference and other unconscious contents of group members.

Suicide survivors groups are not defined as analytical, but more the so called "container" groups, peer groups or problem solving groups. They are not supposed to deal with unconscious material and transference, so the therapists usually don't expose their counter-transference to the same extent as analytically oriented group therapists. But nevertheless, counter-transference is always present and the therapist has to be aware of it, cope with it and be able to understand it (Fig.1).

The groups of bereaved after suicide have to reach certain conditions: they have to offer the understanding and accepting atmosphere, facilitate the expression of all emotions, provide the support system for the members, show them basic strategies to cope with loss, try to work on higher self-esteem and selfconfidence of the members and so on. Striving to achieve and sustain these group goals, the therapist(s) is subjected to all sorts of own emotional reactions, including both empathy and counter-transference.

Fig. 1: The difference between analyticaly oriented groups and groups of bereaved after suicide

ANALYTICALY ORIENTED GROUPS	GROUPS OF BEREAVED AFTER SUICIDE
Neurotic and borderline patients	People in crisis
Working on the unconscious material of the patient	Working on the conscious level ("cognitive antidote")
Transference	Peer relationship
Analyzing past experiences	Important is present time ("here and now") and future
Disclosing, changing and transforming the patient's defense mechanisms	Supporting of the patient's defense system
Provoke more pressure and anxiety in patient to obtain changes	Mutual understanding and disburdening
Interpretation	Reinforcement of positive thinking
Individuality	Universality
Passive therapist ("stone face")	Active therapist (expressive)
Reconstruction of personality	Reaching the level of functioning before crisis (before next of kin's suicide)

OUR PERSONAL EXPERIENCE WITH EMPATHY AND COUNTER-TRANSFERENCE

Empathy, being the conscious emotional reaction, is the feeling that any therapist undoubtedly experience when dealing with groups or individuals, bereaving suicide. Empathy is inevitable as the therapist in the survivors group realizes how irreversible and tragical each survivors situation is and what powerful emotions it provokes. It

is one of the main factors that help the survivors to vent, understand and grow. Being a conscious emotional reaction, empathy is easier to recognize.

E.g.: Mother of a 16-year boy, who shot himself tells the group her story of finding the son's body. The details that she recollects are gruesome, difficult to listen to, at times even horrible. The usual reaction that she experiences in her enviroment, is: "Don't remember this any more. Forget it as soon as posssible. Think about your other child." The group and the therapists react quite opposite: they listen, they stimulate each other with additional questions, they try to understand - they feel empathy. Why can their reactions be different? The other members can feel empathy because they are in the same shoes and can feel what this mother needs. The therapists, on the other hand, are trained to open all subjects, even taboos. Sometimes, however, it seems difficult to open, understand and accept these universally painful themes.

When the therapist finds some of his reactions or emotions difficult to comprehend, the reason probably lies in his countertransference.

After five years of working with suicide survivors (both in groups and individuals), we can list some of the emotional reactions, we suspect to be derived from our own countertransference feelings.

* After the group session, full of emotional turmoils, the therapist feels insecure, anxious, horrified, quite similar to the survivors feelings. E.g.: when listening to the parent, whose child committed suicide, the therapist starts thinking of his own children and why is he/she rather not with them. These thoughts can accelerate to developing the fear that the therapist's child might become suicidal.

* It is difficult to end the therapeutic process. The therapist settles with some survivors suggestions to remain in contact, even informally (trips, coffee), which are difficult for him to keep.

* Trying to achieve too much in too short a time. The therapist knows that the bereavement process usually lasts at least a year, but nevertheless expects the members of the group to show the improvement, to smile, to report feeling better and not to complain on every session. The goal of these groups is to ease the process of bereavement, which doesn't necessarilly show in the immediate improvement of survivors mood. At the same time, this improvement provides any solid feed back of the effectiveness of the therapy.

* The therapist has a need to show too much sympathy, wants to disburden the survivors and wish to protect them, or some of the therapists acting outs (boredom, sleepness, inpatience) probably derive from the unrecognized counter-transference. These reactions might be connected to the therapist's fear of his own death or the death and loss of somebody close. There are at least two types of therapist's behavior deriving from the unrecognizables counter transference:

- The urge to do too much for the survivors: showing too much sympathy, trying to disburden the survivors, wishing to protect them against everything and everyone (e.g.

Therapist feeling the same anger towards the enviroment of the bereaved that supposedly doesn't understand them);

- emotional reaction of the therapist in the form of different behavior: inpatience, not paying enough attention to what was told, withdrwal with boredom or sleepness.

DISCUSSION

Working with suicide survivors provokes a lot of countertransference feelings in therapists, some of which we were not able to mention - from a simple reason, that our inner unresolved conflicts prevent us to recognize and understand them.

One of the obvious questions always arises - why does a therapist decide to work with survivors after suicide? Is it an example of a counter-phobic behavior on the side of the therapist? Or is this decision motivated by purely rational reasons, such as many suicides in the enviroment or the lack of this service, etc?

It helps, if the therapist is not working alone in this stressful situation. Working by himself provokes much more pressure on the therapist and he is far more left alone to his own countertransference reactions, so it is helpful for the group and the therapist if he is working in a twosome. It is useful if the therapists are complementary in their personality traits and style of responding to the group process. They allow each other to vent after each session and so to regain their inner psychological equilibrium.

But the main hope to get close to one's own counter-transference remains as usually - a thorough and constant supervision.

REFERENCE

Yalom, I.D. (1985). The Theory and Practice of Group Psychotherpy. New York, Basic Books, 324-386.

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