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Countertransference in counseling the terminally ill client

Abstract

According to many authorities, probably the most universally shared human fears are those surrounding death (Clarke, 1981; Kubler-Ross, 1969; Momeyer, 1985). In counseling 11 life-threatened¹¹ or dying clients, there is an urgent need for empathy and transparency on the part of the counselor. Ideally, it is essential for counselors to resolve as much as possible their own conflicts concerning "death issues" so that they are more able to help clients work through their own unresolved conflicts concerning the impending death.

COUNTERTRANSFERENCE IN COUNSELING THE TERMINALLY ILL CLIENT

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According to many authorities, probably the most universally shared human fears are those surrounding death (Clarke, 1981; Kubler-Ross, 1969; Momeyer, 1985). In counseling "life-threatened" or dying clients, there is an urgent need for empathy and transparency on the part of the counselor. Ideally, it is essential for counselors to resolve as much as possible their own conflicts concerning "death issues" so that they are more able to help clients work through their own unresolved conflicts concerning the impending death.

A preliminary review of the literature indicated that the issue of countertransference in counseling dying clients is one which is commonly agreed to exist (Clarke, 1981; Dunkel & Hatfield, 1986; Goldberg, 1984; Momeyer, 1985; Wiesman, 1981). If both positive and negative aspects are potentially inherent within the countertransference process, as many current authorities suggest, and if the countertransference process is, in fact, impossible to completely avoid, it seems of importance to become more familiar with and aware of the process of countertransference. Familiarity with and awareness of the process of countertransference seems especially crucial because the process appears to be widely thought of as a negative influence (Clarke, 1981; Newlin & Wellisch, 1978; Watkins, 1985; Weisman, 1981).

The purpose of this paper is to review the literature regarding the issue of countertransference on the part of the counselor in counseling clients who are terminally ill. An attempt will be made to provide a working definition of countertransference, and further, to examine those defense mechanisms, coping devices and behavior patterns which are potentially present in counseling relationships with terminally ill clients.

The value of this investigation lies in its effort to increase counselors' awareness in order that they may examine their perceptions of their terminally ill clients, as well as their personal issues surrounding the process of dying. It is important for counselors to understand the implications of the countertransference process as it relates to counseling terminally ill clients. By first acknowledging that countertransference in the relationship is likely to occur, and second, by identifying ways in which they can be open to dealing with its existence, counselors can better assist clients to receive maximum value and meaning from the therapeutic endeavor. In this paper it will be assumed that accepting and understanding the countertransference process as it relates to counseling terminally ill clients is a prerequisite to successful counseling.

Definition of Countertransference

The question of countertransference on the part of the therapist is one which has received a great deal of investigation and research since the concept was first identified by Freud as an unconscious process involving the therapist's unresolved positive or negative conflicts (Dunkel & Hatfield, 1986).

According to a number of current authorities (Clarke, 1981; Dunkel & Hatfield, 1986; Goldberg, 1984; Peabody & Gelso, 1982) countertransference need not be viewed as a negative process. Rather, Peabody and Gelso point out that it may provide data for diagnosis and intervention.

Watkins (1985) labeled the two basic approaches to conceptualizing countertransference as "classical" and as "totalistic." The classical approach accepts Freud's definition, while the totalistic approach accepts the current, much broader definition (Kernberg, 1965).

In Freud's classical version, countertransference is viewed as those distorting elements which the counselor actualizes in the counseling situation by displacing onto the client emotional material which actually stems from the counselor's distortions and unresolved conflicts (Bellak & Faithorn, 1981; Reid, 1980).

In the totalistic approach (Watkins, 1985), countertransference is seen as a manifestation of anything the counselor thinks, feels or does. Watkins (1985) presented a third view which has evolved over the last decade as that of countertransference possessing both positive and negative elements.

According to Dunkel and Hatfield (1986) and Peabody and Gelso (1982), Freud defined countertransference in a restrictive way which referred to the therapist's "neurotic" transference reactions to the client, and served as an "impediment" to the therapeutic process. The definition has broadened considerably over the years, and has more generally referred to "any feelings or attitudes the therapist may have toward the client" (Peabody & Gelso, 1982, p. 240). Peabody and Gelso noted that, while Freud's version focused on the therapist's external behavior, the current definition includes the internal dynamics such as feelings, reactions and attitudes of the therapist.

As an example of countertransference, a male counselor whose wife died of cancer may have both positive and negative reactions toward a female client who has cancer. While he may have more understanding and acceptance of the emotions with which his client is dealing, part of the time he may tend to discount complaints or fears which his client expresses

because he is reminded of similar complaints of his dying spouse. In addition, past intense feelings of helplessness in dealing with his wife's illness may surface, causing him to be overprotective or rejecting or both towards his client, depending upon his ability to put aside his own "material." In one sense he might be overidentifying with the client while in another sense, he might be disidentifying. Both reactions, however, would come about because of his own unresolved personal issues.

The literature supported the belief that countertransference arises as a result of the counselor's overidentification or disidentification with the client (Bellak & Faithorn, 1981; Dunkel & Hatfield, 1986; Peabody & Gelso, 1982; Watkins, 1985). Identification refers to the counselor's ability to relate to or share experience with clients. Peabody and Gelso agreed with Stensrud and Stensrud (1984) that, when the counselor is touched in an area where he or she has unresolved issues, conflictual and irrational reactions may result.

Identification and Empathy in Relation to Countertransference

Peabody and Gelso (1982) found that, while countertransference and empathy were negatively related, the measure of openness to countertransference feelings on the

part of the counselor was positively related to empathic ability. Thus, counselors with high empathic ability were more likely to experience conflictual feelings in response to client material, but less likely to act out their countertransference reactions. Counselors who become too preoccupied with their own feelings subsequently are in danger of becoming entrapped in countertransference. Peabody and Gelso (1982) concluded that a certain amount of identification with the client on the part of the counselor is necessary in order for the relationship to be of maximum value. Dunkel and Hatfield (1986) also saw identification to be a necessary part of the empathic process with clients.

Watkins (1985) suggested that one way of looking at the countertransference process would be to envision a continuum, with the area of optimal identification at midpoint. At the right extreme, overidentification would represent those behaviors of the counselor in which distance is lost, and he or she becomes "enmeshed" in the client's material or is unable to remain adequately separated from it. To the left extreme would be disidentification in which the counselor might be aloof, cold, nonempathic, or even antagonistic and hostile.

Coping Mechanisms of Terminally Ill

There is little consensus in the current literature as to the number, identification, and classification of defense or grief mechanisms used by persons facing death (Clarke, 1981; Dunkel & Hatfield, 1986; Wiesman, 1981). However, if this countertransference process is an inevitable element, as is popularly believed (Clarke, 1981; Dunkel & Hatfield, 1986), the inference may be drawn that the counselor, as well as the terminally ill client, may experience or engage in the use of defense mechanisms and coping reaction patterns during the counseling process.

It appears impossible to completely delineate or quantify those elements most likely to be present in a countertransference process with a specific dying person. However, some coping mechanisms which are believed to be potentially present in the behavior of dying persons follow.

Yorick Spiegel (1977) suggested eleven defense mechanisms which might be viewed as "coping reaction patterns" by one who is dying. They included: breakdown of reality testing, denial and repression, searching, mania, protest, search for the guilty, identification with the aggressor, helplessness, recollection, incorporation and substitution.

Elisabeth Kubler-Ross (1969), in her experience with dying persons, described the "coping devices" which accompany

the process as: denial and isolation, anger, bargaining, depression, and acceptance. It is agreed by many other researchers (Oates, 1981; Hardt, 1978; Wambach, 1985), that these stages follow no clear progression and, in fact, may exist in a random or combined fashion, or not at all. There is a consensus, however, that counselors need to be aware of the "mechanisms" which terminally ill clients use in order to provide maximum help and support (Clarke, 1981; Dunkel & Hatfield, 1986; Hardt, 1978; Hyland, Pruyser, Novotny & Coyne, 1984; Oates, 1981; Singer, 1983; Wambach, 1985).

Death Anxiety

Another area where countertransference is likely to be encountered is death anxiety. For example, Dunkel and Hatfield (1986) have suggested that particularly in the case of health care providers working with AIDS victims, there is a high priority on "beating death." Accompanying the desire to "beat death" may be a counselor's attempt to deny helplessness and thereby gain some feeling of control over his or her client's fate. The counselor may then behave toward the dying person as if something can and will occur to allow the dying person to "avoid" dying.

Fear of death on the part of both counselors and clients may well be inevitable and, therefore, it must be viewed as a part of the "human condition" (Momeyer, 1985). While the fear

of death on the part of many counselors may be unavoidable, fearing death is not the same as "denial" of death (Momeyer, 1985). By candidly acknowledging their own personal fears, counselors may be more likely to avoid becoming trapped in a countertransference process (Momeyer, 1985).

Denial

Denial is the one mechanism which, throughout the literature, is viewed as most detrimental on the part of either counselor or client (Clarke, 1981; Dunkel & Hatfield, 1986; Hyland, Pruyser, Novotny, & Coyne, 1984; Kubler-Ross, 1969; Momeyer, 1985; Watkins, 1985; Weddington & Cavenar, 1979; Yalom & Greaves, 1977). Carried to extreme, denial may even be viewed to be working in the counselor's choice of clients and setting, in which "good" reasons not to work with certain people are found by the counselor, thereby avoiding dealing with questions of life and death (Dunkel & Hatfield, 1986).

Hyland, et al. (1984) described how the unwillingness or inability of both therapists and participants to acknowledge the approaching death of one of the group members proved destructive to the women involved in a group of breast cancer patients. The group provided no overt acknowledgement of the approaching death either to the dying member or to each other. Even following the death of the member, the counselors

confined their interventions to informing the group about how the member's family was coping, but failed to confront the issue of the member's death directly. In retrospect, the facilitators admitted that denial appeared to have been blatant. Hyland, et al. commented that denial, as a mechanism, was used by both patients and counselors, and cautioned that protectiveness may sometimes be employed as a resistance. This behavior appears to be an example of what Watkins (1985) termed "benign" countertransference in which an atmosphere of optimism and cheer with a general denial of negative issues prevails. It should not be assumed, according to Hyland, et al., that simply because one has had experience working in the areas of death and dying, that resistances have been broken down. In fact, because resistances become more difficult to identify, they may be more difficult to overcome. It appears that the human ability to adapt and integrate both positive and negative ideas and perceptions inherently carries with it the potential for building defenses.

Clarke (1981), surveying the American Psychoanalytic Association to explore the nature of countertransference toward the dying and the extent to which its denial might hinder the therapeutic relationship, found that only forty-three percent had ever worked with a dying patient, forty percent of the respondents had not discussed their own

funeral plans with anyone, and twenty-eight percent had not written their wills. His interpretation of these responses was that the manner of dealing with death-related issues in their own lives pointed to an unwillingness on the part of the professionals to examine those issues with clients. Clarke concluded that countertransference often takes the form of either denial of the impending death of the dying client or of the counselor's own immortality, or both. In addition, denial of the existence of countertransference negatively impacts the therapeutic relationship.

Caregiver's Plight

Newlin and Wellisch (1978) and Glasser and Strauss (1968) concurred that the course toward death can be, and often is, as difficult for caregivers as for the dying patients. In "Caregiver's Plight," Weisman (1981) claims that caregivers may become more distressed by the plight of their dying patients than are the dying patients themselves.

A loss of self-esteem or demoralization or even a change of vocation on the part of the caregiver may occur. Such distress signals on the part of caregivers, rather than being viewed as negative, may signal an "unfolding adaptation" which may ultimately strengthen the relationship between the dying person and the caregiver. Weisman suggested that caregivers

need to practice self-examination to determine why they react with anger, frustration, guilt or depression in a relationship with a dying person.

Vachon (1979) pointed out that personal and professional problems which caregivers develop in terminal care settings may be the result of emotional burdens which the caregivers feel and then place upon their patients. Because of their constant exposure to death, they may eventually succumb to depression, acting out, or any number of other behaviors and attitudes which detract from their ability to provide maximum support to dying patients.

Termination/Separation Issues

The termination phase in the "traditional" therapeutic setting is seen as potentially the most important phase by many professionals (Bellak & Faithorn, 1981; Edelson, 1963; Fox, Nelson & Bolman, 1969; Hiatt, 1965; Ingram, Hurley & Riley, 1985). Edelson (1963) suggested that, during this termination period, the therapist becomes aware that the issues being worked through by the patient are logically applicable to the therapist, as well. Edelson saw a dread of separation as one potentially important reason why many psychotherapists avoid and deny the issues of rejection, loss, and abandonment which clients often express, as they are experiencing those same feelings themselves.

Termination issues between a counselor and a terminally ill client would perhaps occur with more intensity, due to the "permanency" and "magnitude" of those issues implied in the separation. In a very urgent sense, the dying client may present the termination issue to the therapist, at which point the therapist must deal with it. The "imposed" termination, according to Weddington and Cavenar (1979), may well increase countertransference potential for the therapist.

Goldberg (1984) examined the impact of her own life-threatening illness on her counseling relationships. She reported that when certain characteristics of her clients happened to coincide with her own, a strong and initially unacknowledged countertransference occurred on her part.

As one example, Goldberg (1984) cited her fear that those group members with whom she worked who were nearer her own age might leave the group she facilitated, rather than deal with death issues in themselves which arose in regard to the therapist's illness. Goldberg later realized that she was projecting onto the group members those feelings with which she was having difficulty dealing personally. She reported her eventual need to confront herself with the question of why she was choosing to see the knowledge of her illness as a barrier to therapeutic work, rather than as a stimulus for working through conflicts concerning death. Her personal

conclusion was that the adults in her group were seen by her as parental figures to whom she "both wished and feared to return to for protection" (p. 295). Goldberg concluded that those instances in which she was eventually able to share candidly the nature of and reaction to her own illness provided for development of greater intimacy and support than she had previously experienced as a therapist.

If one accepts the existence of destructive countertransference patterns, one would logically see these patterns as having negative implications for any counseling relationship in which they might occur. They further might be viewed as potentially devastating in relationships with dying clients at a time when a high degree of objectivity on the part of the counselor would be most in demand. Watkins (1985) suggested five methods which the counselor might employ to combat negative countertransference behaviors. They include self-analysis, personal counseling supervision, genuineness, self-disclosure, and referral.

Dunkel and Hatfield (1986) suggested that counselors must maintain professional awareness. This awareness must include the following: understanding that such countertransference issues may occur, and how they may be disguised; identification of personal vulnerability to such issues; education and self-desensitization; self-awareness through the

use of tapes, process recording, role-play; self-control practice of countertransference reactions; knowing one's limitations, and the use of a peer-support system (Dunkel & Hatfield, 1986). A study of these methods lies beyond the scope of this paper.

Conclusion

The following conclusions may be drawn from reviewing the literature. There is common agreement among members of the counseling profession that the process of countertransference potentially exists in counseling terminally ill clients. Two schools of thought exist in regard to dealing with this potential countertransference. On one hand, there are those who believe that the counselor must have resolved his or her own "death issues" in order to be maximally helpful to terminally ill clients. On the other hand, there are those who see that possibility as realistically unattainable in most cases. Those who share the latter opinion encourage the approach of the counselor to be one of a kind of "genuine immediacy," in which he or she may express his or her own doubts, fears, or confusion, honestly attempting to assist such a client in a process which is relatively "foreign territory."

Authorities such as Elisabeth Kubler-Ross (1969) tend to view the role of the counselor as one in which the best that

may be hoped for is an attempt by the counselor to trust his or her own self-process, and to be a nurturing helper who facilitates the death process in the client. Kubler-Ross is one who holds the view that the counselor must have dealt with his or her own death issues in order to help the client do the same, however (Klass & Hutch, 1985).

At present, most authorities on the subject of countertransference with terminally ill clients appear to agree with the position taken by Dunkel and Hatfield (1986) who suggest that counselors must maintain professional awareness of the countertransference process and continually take steps to "examine" their vulnerability.

The concept of countertransference is one which may be of concern in any counseling relationship. As counselors, we need to view any problem which we encounter with our clients as a challenge to be processed with the client, be it death or dying or any other issue.

As Stensrud and Stensrud (1984) have suggested, what we do with clients may be considerably less important than who we are. They believe that the personal, healing presence of the counselor, apart from any training and professional skills, is of supreme importance, no matter what the concern of the client. The counselor's dedication to the concept of "Physician, heal thyself," appears to be the most essential

component in any therapeutic endeavor from their point of view.

There is need for awareness of this complex process on the part of counselors of terminally ill clients in order to give these clients the maximum opportunity to make their own independent decisions and to grow in this process.

Implicitly, clients may then receive maximum support and assistance of the counselor without the additional burden of the counselor's unresolved death issues and concerns.

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