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Julia A. Jakubowski
Implicit Communication:
The Body's Role in Clinical
Work with Trauma Survivors

ABSTRACT

This exploratory-descriptive study examined therapists' use of their physiological responses in work with trauma survivors. Broadly, the study sought to understand how a therapist's physiological responses play a role in how they construct meaning about a client. The study sample consisted of eight Relationally oriented therapists who worked with trauma survivors. Data were collected through hour-long, semi-structured interviews with each participant at a single point in time, utilizing the Physiological Response to Trauma Questionnaire. Findings revealed that participants used their physiological countertransference to inform clinical functions, specifically: ability to attune, choice of interventions, assessment, and ability to maintain boundaries and prevent vicarious trauma.

IMPLICIT COMMUNICATION:
THE BODY'S ROLE IN CLINICAL WORK WITH TRAUMA SURVIVORS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2012

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CHAPTER I

Introduction

The purpose of this qualitative research study was to explore the role of therapists' physiological responses in their work with trauma survivors. The topics relevant to this study are: countertransference (CT), including somatic countertransference (somatic CT), therapists' clinical experience of trauma treatment, Relational Theory, intersubjectivity and mutuality.

The study explored the role of therapists' physiological responses in their work with trauma survivors; it sought to examine the role of clinicians' physiological responses in their ability to attune, choice of interventions, assessment, ability to maintain boundaries and prevent vicarious trauma. This project used a Relational lens to understand clinicians' physiological responses as countertransference, drawing on somatic countertransference literature.

Countertransference was explored within the relational concept of the intersubjective space, understanding physiological response to be part of the subjective experience of the therapist's interactions with the client.

There is a moderate amount of literature exploring the clinical use of managing countertransference (CT) when working specifically with Post Traumatic Stress Disorder (PTSD) (Vesper, 1998; Vulcan 2009; Long, 1999). At the same time, contemporary countertransference literature speculates about therapists' use and management of their somatic experiences in therapy. There is an increasing amount of literature proposing to include therapists' physiological response within a contemporary concept of CT.

This study is relevant to the practice of social work and to mental health therapists in particular, as it explored the implications of the role of countertransference in clinical practice. Specifically, it looked at how countertransference interacts with variables that direct therapists' clinical effectiveness and their ability to attune, their choice of interventions, assessment, and the ability to maintain boundaries. Explorations of therapists' somatic experiences during therapy, when viewed as countertransference, also contribute to literature that links the management of CT as a protective practice against Vicarious Trauma. Pearlman and Saakvitne (1995), first coined the term Vicarious Trauma (VT), and argue that therapists' awareness of CT can function as a protective factor for VT. Countertransference literature argues that ethical and legal violations can ensue from the mismanagement of countertransference, specifically when working with PTSD (Vesper, 1998). A better understanding of the role of countertransference has relevance for practice and education, as well as in practitioner self care and efficacy.

The purpose of this study was to deepen our understanding of how relational therapists use their physiological responses in work with trauma survivors. This work was largely influenced by Relational theorists like Stolorow and Atwood (1992), who have written about the relationship between the mind and body in self-experience. Stolorow and Atwood (1992) proposed that further exploration of the relationship between the body and mind in awareness will contribute to better understanding the central dimension of human self-experience. Relational Theory informed this study in its focus on intersubjectivity, and its inclusion of therapists' multiple experiential subjectivities in an understanding of countertransference. Recent theorists provided this study with a framework from which to view countertransference as a subtle and dynamic interaction that creates therapeutic meaning at both the explicit and implicit levels of communication. The shift towards an exploration of the role of implicit communication

in CT informed the researcher's thoughts and interpretations about the role of physiological responses in proposing the study

This study defined intersubjectivity as the reciprocal, mutually influencing quality of interactions between clinician and client, within the context of therapy (Benjamin, 2004). Working from the theoretical framework of intersubjectivity, the study maintained an emphasis on context, reciprocal interaction, empathy, and mutuality in viewing trauma in clinical practice and on its impact on the therapist's experience and clinical functioning (Rasmussen, 2005). In understanding the concept of mutuality, this study drew heavily from writings from the Stone Center (Surrey, 1997). In considering mutuality, this study explored the role of a therapist's physiological responses in their ability to ethically foster mutuality. Surrey (1997) describes mutuality as a way of being emotionally responsive, empathically attuned, authentically present, and open to change in the therapeutic relationship. Finally, this research broadly used a Relational description in understanding the idea of countertransference, viewing it as the dialectic between the clinician's subjectivity and the client's subjectivity.

This qualitative study explored the following research question: What is the role of therapists' physiological responses in their work with trauma survivors?

CHAPTER II

Literature Review

Literature was reviewed regarding how the concept of countertransference (CT) has been constructed and defined historically, as well as within the context of working with trauma survivors. As theoretical understandings of countertransference have changed, the literature illustrates how perceived functions and clinical implications of countertransference continue to remain subjective. Most importantly, the review explores the idea of countertransference from a Relational perspective, and its interaction with the concepts of intersubjectivity and mutuality. Recent theorists provided this study with a framework from which to view countertransference as a subtle and dynamic interaction that creates therapeutic meaning at both the explicit and implicit levels of communication. The shift towards an exploration of the role of implicit communication in CT informed the researcher's thoughts and interpretations about the role of physiological responses in proposing the study. Finally, in supporting this perspective, recent literature and empirical research are reviewed that have sought to study and to measure therapists' physiological experiences in their work as somatic or body-centered countertransference.

Countertransference and Relational Theory

The concept of countertransference (CT) has been evident in western psychodynamic literature since the work of Sigmund Freud (1990). Historically, the term has been operationalized primarily at the behavioral, cognitive and affective levels; however, its definition

has varied (Vulcan, 2009; Booth, Egan, & Trimble, 2010; Long, 1999). While Freud (1988) discussed CT as emerging from the analyst's unresolved unconscious conflicts, later theorists, like Reik (1948), suggested that the term denotes the inner experience a clinician is able to perceive, feel and sense in reference to their client. Since then, the term continues to be elusive to define. For the purpose of this study, focus will be placed on a smaller body of work within the larger framework of CT literature that focuses on the topic of countertransference and PTSD (Long, 1999). This literature proposes the use of a Relational lens in viewing the role of countertransference in clinical work with trauma survivors.

Pearlman and Saakvitne's work (1995) elaborates on earlier research that explored countertransference hazards distinct to the work of trauma therapists. They elaborate on these findings by including in their definition of CT not only the affective ideational responses a therapist has with her client, but also her physical responses. Citing Pearlman and Saakvitne (1995) as countertransference theorists, it is possible to view their work as directing the literature toward including a therapist's physiological responses in an understanding of CT.

Hayes and Gelso (2001) define countertransference as the therapist's reactions to clients that are based on the therapist's unresolved conflicts, and go on to refer to the clinical use of CT as the "use of the self" (p. 1041). In their synopsis of the past 50 years of research on the use of CT, Hayes and Gelso (2001) argue that future research pertaining to countertransference (CT) should be directed toward an understanding of how therapists can use the concept of the self as a tool to enhance their work with clients, rather than re-creating past research that has focused on the impediments that occur through the use and management of CT reactions. An impetus toward viewing therapists' use of CT in therapy as potentially positive is corroborated by Surrey (1997), who speculates that a lack of mutuality and authenticity on the part of the therapist is more likely

to create a negative experience than the good use of mutuality would, within the therapeutic context. This literature corroborates by placing focus on the role of a therapist's self-experience in therapy, and how their self-awareness functions within an understanding of CT.

In the past 30 years, Relational Theorists like Stephen Mitchell (1988) and Jessica Benjamin (2004) have proposed a psychoanalytic framework that views the individual as understandable within relationship, and the relational field as being created by the client *and* the clinician's subjective internal experience. Countertransference, from a relational perspective, is understood as a dynamic process in which the therapist attempts to take part in and gain awareness of the dialectic between their own subjectivity and that of the client. Viewing the transference-countertransference interaction through this lens, this study seeks to explore the role of a therapist's physiological responses within the subtle, intersubjective interactions that occur with their clients. Relational literature points towards an understanding of countertransference at the subtle level, but there is a lack of research and literature that addresses the role of a therapist's physiological experiences in CT.

Within the realm of social neuroscience, contemporary researchers like Pally (2010) maintain that human survival depends on interpersonal relations. Pally (2010) contends that humans possess brain mechanisms called shared circuits that operate by re-creating the Other's experience in the same brain regions used for Self experience. Using clinical vignettes, Pally's (2010) study sought to illustrate the clinical use of shared circuits, proposing that these brain mechanisms play a role in the transference-countertransference interaction. This study contends that interpersonal understanding occurs primarily outside conscious awareness. It illustrates how science is beginning to corroborate Relational Theory's focus on the interaction of

therapist/client subjectivity within the intersubjective space, and it shifts focus from explicit communication to implicit communication.

Eagle (1993) conceptualizes a client's improvement in psychoanalysis as influenced by a "corrective emotional experience" with the therapist. He proposes this experience is a result of implicit communications and interpretations between client and therapist, which have a correctional function for the client. Viewing the transference-countertransference interaction through a lens that includes implicit, or non-conscious communication, it is possible to place physiological experience in this subtle interaction. Eagle (1993) questions the degree to which the client 'actively' engages in a variety of physiological activities, non-consciously or otherwise, that might elicit physiological activity in the therapist. He conjectures that communication need not be explicit in order for it to function therapeutically.

In psychoanalytic literature, the question of how therapists make interpretations is problematic, and varies depending on the theoretical framework of the writer. In relational analysis, there is a focus on how therapists enact their own material with their clients, and how this interaction provides material for the clinician to reflect on and to construct meaning about the individual (Knoblauch, 2005). More recent Relational Theorists, like Knoblauch (2005), are asking the question, how do therapists construct meaning (about their client)? Knoblauch (2005) discusses the limitations of language in providing accurate symbolization for a client's experience, and proposes incorporating nonverbal embodied communication in addition to language, as a gateway into the unconscious meaning in therapeutic action.

Following this, Bennett's (2008) study is illustrative of more recent research being done that places attention on the role of a therapist's attachment style in the therapeutic relationship. Bennett (2008) sought to examine the role of attachment processes in countertransference and

transference dynamics within the supervisor-therapist-client triadic relationship. He found that secure attachment within the supervisory relationship was linked to self-reflection and affect regulation of the therapist, concluding that this influenced the therapist's attunement to, and regulation of, the client's affect in psychotherapy (Bennett, 2008). This corroborates an understanding of countertransference as containing more than overt, conscious communication, and points to the importance of understanding implicit communications in therapeutic diads.

Exploring the way therapists construct meaning within the therapeutic interaction is imperative in order for professionals to identify biases, maintain ethical standards, and continue to work towards the elimination of social injustices such as racism. The ways in which a therapist makes deductions about an individual's affect, or inner experience, is central to the therapeutic process, and vulnerable to their unexamined countertransference. The literature suggests that meaning is constructed at the subtle level, many times implicitly. A therapist's awareness of their physiological response to their client exists at both the conscious and non-conscious levels, and plays a role in their construction of meaning, which will directly affect their clinical decision-making.

In research and literature exploring the physiological aspects of countertransference, authors have used various terms and applied contradictory meaning to the concept of physiological response. Aspects of therapists' physiological experience of CT have been named somatic countertransference, body-centered countertransference and embodied countertransference.

Somatic Countertransference Literature

Even before Pearlman and Saakvitne's (1995) foundational work in addressing the use of CT with trauma clients, studies connecting trauma work and CT had explored what was first

named, “embodied countertransference.” Field (1989) described embodied countertransference as the spontaneous experience of physical feelings in the therapist that might be unrelated to the client’s manifest material, or even in contradiction to it. More contemporary research has come to define the concept of Body-Centered CT as the therapists’ awareness of their own body, of sensation, images, impulses, feelings and fantasies that offer a link to the client’s process and to the intersubjective field (Vulcan, 2009). Miller (2000) described somatic countertransference as a valuable clinical tool, and encouraged therapists to use body sensation and body knowledge as valuable communication from the client’s body manifestations and unconscious messages. Within the contingent of somatic countertransference literature, countertransference is often viewed from a relational lens, with an emphasis on the use of intersubjectivity (Vulcan, 2009; Long, 1999; Wilson, 2004).

Following this framework, Vulcan (2009) described the therapist as an active participant whose somatic responses are part of the therapeutic interaction. This body of literature was influential on the decision to use a relational/intersubjective lens in this study. This study seeks to build on a relational framework in viewing therapists’ experiences and use of physiological responses during therapy with trauma survivors, as experiences of somatic countertransference.

Orbach (2004) utilized concepts from both Attachment Theory and Relational Theory in her work on body countertransference. She suggested a re-theorization of the relationship between psyche and soma in which the body subjectivity is viewed as having a developmental history of its own, rather than the body being viewed as “a receptacle for unwanted contents of the mind” (p. 142). Orbach said the therapist’s body expresses the relational complexities between client and therapist, and represents the “imaginative and cross transference need of the patient and the therapist (p. 149).” In viewing the intersubjective aspect of the therapist’s body,

Orbach posited that the therapist's body is being used by the client, and that body countertransference should be used clinically to help transform the way client's experience their bodies.

Empirical research on CT within the context of trauma is less evident than theoretical literature on the subject, and the somatic manifestations of CT have yet to receive due consideration (Vulcan, 2009). Therefore, it is impossible to discuss consistency or to speculate about therapists' management and use of somatic CT in clinical interactions with confidence. For example, there exist no measurement tools for measuring traditional "countertransference;" however, the concept is prevalent in psychotherapy discourse. Many of the contemporary empirical studies of CT and Post Traumatic Stress Disorder (PTSD), as well as body-centered CT, are dissertations, and the data is unsubstantiated (Wilson, 2004; Long, 1999; Forester, 2001). Also, a large amount of the literature on body-centered countertransference has a focus on linking CT as a protective factor for Vicarious Trauma with the focus placed more on the symptoms of VT, and less on how the countertransference interacts with therapists' meaning-making.

Within the contingent of literature studying populations of trauma therapists, there are consistent findings that link therapists' awareness of their physiological responses to a decrease in reported symptoms of vicarious trauma. Forester (2001) found that therapists who spent at least 20% of monthly clinical time with trauma clients and who had a greater frequency of practicing body awareness had more inverse variance scores for vicarious trauma. In the study, Forester (2001) developed and utilized a new measurement tool to assess therapists' use of body awareness as a way of managing CT: the Body Awareness Measure, and the Frequency of Practice (of body awareness) Measure. More research is needed to corroborate that a concept of

body awareness can be measured empirically. Forester's (2001) study is illustrative of the small body of research on this topic, which is relevant in its ability to create initial empirical evidence on the concept of Body Awareness and CT, and can be further corroborated or contradicted in future studies.

Egan and Carr (2008) also developed a questionnaire to assess the frequency of somatic/body-centered CT in therapists, and found a relationship between the frequency of CT experienced and the amount of sick leave taken. This questionnaire was used again in Booth, Egan and Trimble's (2010) quantitative study, which looked at the frequency of body-centered CT in a sample size of 84 Irish clinical psychologists. They found that body-centered CT was experienced in some form by the majority of their sample, with almost 80% of the sample experiencing muscle tension in the last six months. The strength of this study is its proposal that body-centered countertransference can be measured using quantitative methods, yielding empirical data. It sought to normalize body-centered CT as an integral part of the therapeutic setting (Booth et al., 2010). However, the use of a questionnaire with structured, non-open-ended questions limited therapists in describing their experience. Additionally, this study utilized a new instrument to measure different variables than it was originally developed for, and failed to corroborate past findings. Quantitative studies like this one fail to get close to the subjective experience and use of physiological responses in the therapeutic interaction, and do not address the implicit or explicit role the therapist's experience of their body might play in clinical meaning making. More studies are needed to explore Stolorow and Atwood's (1992) proposal that an exploration of the relationship between the mind and body will lend insight into how one experiences the self in context, a theme that is foundational to the ethical use of psychotherapy.

The research on somatic countertransference and trauma is proposing to empirically operationalize concepts that are historically ambiguous in the literature, like body awareness, somatic countertransference, and vicarious trauma. The studies are weak in that results are inconsistent, sample sizes tend to be small, and they lack external validity. In summary, recent trends in the discourse of mainstream psychotherapy and neuropsychology highlight the role of the body in the therapeutic encounter, and a new idea of countertransference has emerged, which has been named body-centered countertransference or somatic countertransference. The limitations of the literature are a lack of empirical studies, and a lack of replication and quantitative data on somatic CT. As discussed earlier in this section, literature on CT and trauma has sought to explore the interaction of CT and vicarious trauma in therapists. Empirical studies have begun to create and test scales to measure body-centered CT, and more research is needed to replicate findings, to operationalize and define terms, and to further support or diverge from the patterns that have been identified. This study seeks to build on the findings of this body of research, exploring the role of therapists' physiological responses in their work with trauma survivors.

Role of Countertransference in Clinical Functions

This study explored the way therapists' physiological experiences in therapy interact with clinical functions, specifically in therapists' ability to attune, choice of interventions, assessment, and ability to maintain boundaries and prevent vicarious trauma. It sought to understand how a therapist's physiological response might play a role in their meaning-making about a client.

As previously stated, the concept of countertransference has been linked to various aspects of therapists' clinical functioning. Pearlman and Saakvitne (1995) linked CT as a protective factor for vicarious trauma, and later Pearlman and Caringi (2009) proposed that CT

and vicarious traumatization can challenge therapists' ability to attune to clients' needs and their ability to create the empathic engagement necessary to form an authentic therapeutic relationship. Pearlman and Caringi (2009) were almost certainly understanding CT in a classical sense, and viewing its evidence in therapy as counter to the therapeutic process. This type of literature, while not rooted in Relational Theory, corroborates an understanding of clinical effectiveness from a Relational lens that would name a therapist's ability to empathically engage in the foundation of mutuality as integral to the healing process. Surrey (1997) writes specifically about how change occurs in the context of a therapy session, proposing that in practice, mutuality is key, and for a therapist this means being empathically attuned, emotionally responsive, authentically present, and open to change. Surrey (1997) is linking the presence of mutuality to attunement, assessment, and arguably, appropriate boundary making. This study builds on the literature by further exploring the role of Relational therapists' physiological experience in achieving mutuality, thus linking therapists' awareness of their physiological responses to clinical functions like attunement, assessment and boundary making.

Furthermore, Orange, Atwood, and Stolorow (2001) propose that a focus on intersubjectivity informs a therapist's determination of what approach is appropriate with a particular client. An awareness of the intersubjective space allows the therapist to consider the context of time and the nature of the interaction and emotional states of both themselves and the client in determining not only what is appropriate, but also what is possible (Orange et al., 2001). This speaks directly to the role of intersubjective awareness in the clinical function of assessment, which will also affect their choice of intervention. By viewing therapist's physiological responses as part of the intersubjective space, this study will explore the role of somatic countertransference in assessment and intervention. As stated earlier, Miller (2000)

described somatic countertransference as a valuable clinical tool, and conceptualized therapists' body sensation and body knowledge as valuable communication from the client's body manifestations and unconscious messages.

In an exploration of therapists' clinical functions with trauma survivors, it is necessary to explore a brief Relational understanding of trauma. In working therapeutically with trauma, Stolorow and Atwood (1992) propose that trauma lies in an individual's experience of unbearable affect, and should be understood in terms of the relational system from which it emanated. Rasmussin (2005) corroborates this framework, writing that pathology is not located solely within the individual client, but should be understood "within the intersubjective configurations and emotional contexts from which it is embedded" (p. 23). Following this, a therapist's appropriate assessment of trauma and of proper therapeutic intervention hinges on their awareness of the intersubjective field, of the client's development, as well as in the past and present relational contexts. More specifically for this study, appropriate assessment hinges on a therapist's understanding of a concept of CT, or the dialectic between their own subjectivities, and that of the client. Furthermore, this study wishes to explore the role of a therapist's physiological response within this dynamic process.

Summary

A major weakness found in this literature review is that prior work on countertransference, including somatic CT, has not included issues of diversity, for example how a therapist's experience of privilege, power, race or class, with their client, can be experienced in the body, how bias and racism might be implicitly communicated, and how this effects their clinical decision-making. Research is needed that will address the interactions between a therapist's physiological countertransference and these diversity issues. This study's use of

Relational Theory seeks to address this lacunae in the literature, as therapists working intersubjectively are conceptually examining their own subjectivities, and seeking an awareness of how they enact their embodied relationships with privilege, power, race and class. In his discussion of Relational Theory, Aronson (1996) writes that following the Stone Center's model, pathology occurs through emotional disconnection and a breakdown of empathy that is pervasive in western culture. A therapists' active work to build awareness of their internalized racism, for example, or her unique internalized experience of cultural values, is imperative to limit the perpetuation of social injustice through the medium of the therapeutic relationship.

The literature review reflects a lack of research on the use of a therapist's physiological response in therapy with trauma survivors, as it informs their awareness/management of countertransference. This study seeks to better understand how a clinician uses their physiological responses in their work with trauma survivors, specifically relational practitioners with an understanding of countertransference and mutuality within the intersubjective space.

CHAPTER III

Methodology

This exploratory-descriptive study examined therapists' use of their physiological responses in work with trauma survivors. This qualitative study focused on examining the role of clinicians' physiological responses in their ability to attune, choice of interventions, assessment, ability to maintain boundaries and prevent vicarious trauma. The study included both quantitative and qualitative components and addressed the following research question: How do therapists use their physiological responses in work with trauma survivors? The researcher gained approval from the Smith College School for Social Work Human Subjects Review Committee to conduct this research study.

Sample and Procedures

The sample included eight therapists, who were recruited to voluntarily participate in the study. The sample was obtained via recruitment from the following organizations: (a) the Washington State Society for Clinical Social Work; (b) the Oregon Society of Clinical Social Workers; (c) the Seattle Psychoanalytic Society and Institute; (d) the Pacific Northwest Psychoanalytic Society; and (e) the Northwest Center for Psychoanalysis. The sample of participants is not considered a vulnerable population. The researcher contacted Carolyn Sharpe, President of the Board of Directors for the Washington State Society for Clinical Social Work, John Milnes, President of the Oregon State Society of Clinical Social Workers, Victoria Jenkins, Head Administrator for the Seattle Psychoanalytic Society and Institute, Bev Osband, the

President of the Pacific Northwest Psychoanalytic Society and Steven Scherr, President of the Northwest Center for Psychoanalysis, and was able to obtain their permission to post a recruitment script (see Appendix A) on their respective listservs/newsletters to get voluntary participants for this research study. These organizations do not have Human Subject Review Boards or Institutional Review Boards that would require submission of an application for approval to conduct this proposed research project. In the case that the recruitment script was distributed electronically, letters of consent were obtained from the organization. Inclusion criteria for participants are as follows: (a) Washington or Oregon State licensure as a mental health professional, licensed independent clinical social worker, licensed clinical social worker, or psychologist; (b) English-speaking; (c) at least five years clinical practice post licensure; (d) current or past therapeutic practice experience with trauma survivors; and (e) utilization of Relational Theory in clinical practice. Exclusion criteria are as follows: (a) lack of licensure in Washington or Oregon State as a mental health professional, licensed independent social worker, licensed clinical social worker, or psychologist; (b) non-English-speaking; (c) less than five years of practice post-licensure; (d) lack of current or past therapeutic practice experience with trauma survivors; (e) utilization of a theory other than Relational Theory in clinical practice. Snowball sampling was also used; individuals on the aforementioned listservs or newsletters were asked to forward the recruitment script to colleagues who meet the inclusion criteria. The researcher contacted therapists who responded to the recruitment script via telephone and scheduled an appointment for an interview.

Organizations

The Washington State Society for Clinical Social Work (WSSCSW) is a nonprofit tax-exempt professional organization that is affiliated with the Clinical Social Work Association. It

is an organization of clinical social workers practicing in a variety of settings. It offers its members continuing educational opportunities, legislative advocacy, and network and professional growth opportunities. The WSSCSW's mission is to advance the profession of clinical social work by upholding standards of clinical practice through continuing education, advocacy, mentorship, political and/or legislative action, community service, public education and research.

The Oregon Society of Clinical Social Workers is an organization exclusively dedicated to protecting the interests of clinical social workers and their clients in the state legislative and administrative processes. The organization publishes monthly newsletters online for their members, connects members to social work news, events and social work networks in the state of Oregon.

The Seattle Psychoanalytic Society and Institute (SPSI) is a not-for-profit corporation governed by a board of directors. It is accredited by the American Psychoanalytic Association to educate and train mental health clinicians in psychoanalytic treatments, and to train researchers in applying psychodynamic theory in social settings. The Institute offers seminars and continuing education for clinicians, and connects members to each other and to psychoanalytic networks and associates in the Seattle community.

The Pacific Northwest Psychoanalytic Society is the Pacific Northwest chapter of the American Psychological Association. The society's members and board of directors seek to facilitate the study and dissemination of psychoanalytic concepts and ideas. The society sponsors seminars, presentations and monthly scientific meetings in the Seattle region, as well as connecting members to the area's psychoanalytic community.

The Northwest Center for Psychoanalysis (NCP) is an independent, nonprofit psychoanalytic institute and community of professionals. It provides psychoanalytic trainings as well as psychodynamic and psychoanalytic education and training to mental health professionals, students, and to its community. The NCP in particular places a value on relational concepts in treatment, and seeks to promote accessibility to quality mental health care to the Portland community.

Operational Definition of Variables

Physiological responses are conceptualized as the subjective experiences and physical reactions that occur as the result of an individual's conception of the physical self.

Physiological responses are operationally defined by participants' subjective responses to items in the Physiological Responses to Trauma Questionnaire.

Trauma is conceptualized as an individual's experience of unbearable affect, and will be understood in terms of the relational system from which it emanated (Stolorow & Atwood, 1992).

Trauma is operationally defined by participant's responses to the Physiological Responses to Trauma Questionnaire based on their current or past work with trauma survivors.

Measurement Instrument

The Physiological Responses to Trauma Questionnaire is a six-item instrument designed by the researcher. Respondents were told that questions had been formulated to ascertain demographic data, data regarding their ability to attune, choice of interventions, assessment, ability to maintain boundaries and prevent vicarious trauma. The researcher answered any questions regarding this measurement instrument prior to beginning the interviews.

Data Collection

Prior to each interview the researcher asked each subject if she/he voluntarily agreed to participate in this study. The researcher explained the purpose, procedures, benefits, and risks of the study. Each subject was asked to read and sign the Consent for Participation in a Research Study Form (see Appendix B). If any subject had questions about the study and/or consent form all questions were answered before the subject signed the consent form. After each subject stated to the researcher that she/he understood the consent form, she/he was asked to sign the form.

Data were collected at a single point in time using the Physiological Responses to Trauma Questionnaire (see Appendix C) that was developed by the researcher. Each interview lasted approximately 1 hour. Responses to the questionnaire were audio taped and typed verbatim.

Data Analysis

Demographic Data from the Physiological Responses to Trauma Questionnaire were described for the respondents; a frequency distribution is provided for this data. Content analysis was used to analyze the narrative responses to questions regarding physiological responses to trauma while working with trauma survivors including therapists' ability to attune, choice of interventions, assessment and ability to maintain boundaries and prevent vicarious trauma.

CHAPTER IV

Findings

This exploratory-descriptive study examined therapists' use of their physiological responses in therapeutic work with trauma survivors. Eight therapists participated in the study. The primary research question being explored was: How do therapists use their physiological responses in work with trauma survivors? Specifically, it sought to explore how participants' concept of Countertransference interacts with variables that inform therapists' ability to attune, choice of interventions, assessment, and ability to maintain boundaries and prevent vicarious trauma.

Data were collected through semi-structured interviews with subjects using the five question Physiological Responses to Trauma Questionnaire. The data collected were primarily qualitative with a limited amount of quantitative data. This chapter is divided into six sections. Following the Description of Sample, it is divided according to the categories outlined in the Physiological Responses to Trauma Questionnaire: (a) Trauma; (b) Countertransference; (c) Physiological Response; (d) Case Examples of Emotional and Physiological Countertransference; and (e) Interaction of Emotional and Physiological Countertransference.

Participants' responses to specific questions were further analyzed to reveal diverse themes, as shown in each section.

Description of Sample

The sample included eight clinicians. Five participants were recruited from the Seattle Psychoanalytic Institute and Society, and three participants were recruited from the Washington State Society for Clinical Social Work. Interviews were conducted in varied physical facilities to protect the confidentiality of all participants.

The age range for participants was 44-64 with a mean of 55.1. Three participants identified their gender as male, four as female, and one participant stated, "I always object to this question," when asked to identify their gender. The marital status of the participants varied: five were married, two were divorced, and one was partnered. Seven participants reported "Caucasian" as their racial/cultural/ethnic identity; one participant reported "Caucasian," "Multicultural," "American Indian," "Latina/o," and "Mixed Race."

In responding to the demographic information questionnaire, one participant reported they held a Master of Psychology and a Master of Public Health; five participants held a Master of Social Work; one held both a Master of Social Work and a PhD; one held a PhD in psychology. Six participants identified that they had completed psychoanalytic training. One respondent identified their profession as psychology and public health, two as clinical social work, two as social work/psychoanalysis, one did not specify their profession, one specified their profession as psychology, and one as psychotherapist/analyst. Participants' gross annual income ranged from \$15,000 to \$275,000, with a mean of \$98,400. Respondents reported they had been practicing clinicians (post licensure) for a number of years ranging from 14-39 years, with a mean of 25.4.

Participants were asked to identify their theoretical orientations. The theoretical frameworks utilized in clinical practice varied among participants. All participants initially stated

they practiced from a Relational framework. In addition, one participant reported psychodynamic/psychoanalytical, systemic, strength-based perspective, narrative and relational; one reported eclectic, psychodynamic; one reported psychodynamic and family systems theory; two reported psychoanalytic; one reported objects relations, experiential psychology, feminist theory, biopsychosocial perspective; one reported “psychoanalytic theories and varied;” another reported “mostly object relations and ‘mainstream’ American analytic.”

Participants reported the following areas of diverse populations that they have worked with in their practice: one participant reported “tribal coastal Salish Indian tribes, Latino, varying ethnicities and sexual orientations;” one participant reported “transgender, gay, lesbian, other, African American, Indian Philippines, Iran, Iraq, Native American, bicultural/racial, Korean, French;” one respondent reported “all races (white, black, Hispanic, Asian, Pacific Islander)” and “heterosexual, homosexual, lower middle to upper class;” one respondent reported “children of all ages and races... basically I have experienced all of the above;” one respondent reported “general;” one respondent reported “college students total of twenty years in four universities, hospital inpatients (psych) and patients in OP (outpatient) four years, outpatient private practice past or full time since 1972, over eighteen, some experience in gay/lesbian/bisexual populations, seventy percent female, culturally diverse populations;” one participant responded “children, adolescents, adults, all ages, all races, both genders, severely mentally ill, physical illness, trauma survivors, depression, anxiety, all socioeconomic levels all sexual orientations;” one participant responded “HIV/AIDS populations, LGBT populations, eighty percent Caucasian clients in private practice, nine percent Asian and one percent all other, wide variation in income status.”

Conceptualization of Trauma

Participants were asked, “How do you conceptualize trauma?” Their responses were diverse and multi-faceted, there were few consistent themes throughout responses. Four out of the eight participants used language such as “overwhelming” to describe the effect of a traumatic event on a trauma survivor. A theme was the utilization of a “concept of Self” by participants to describe the effects of trauma on the client’s experience of Self. Another theme was the description of the effect of a trauma on the sense of self as “overwhelming,” “disorganizing,” “difficulty in maintaining a cohesive sense of self,” “threatening to the ego and sense of self.” There were also multiple references to the negative effect of trauma on clients’ defenses. For example, one participant referred to the effect of trauma on a client’s defenses as “defense shield damaged.” Similarly, a common theme was the use of the “concept of ego” within participants’ conceptualization of trauma. Trauma was defined by the effect of an event on an individual’s ego, similarly, the effect was described as negative.

Another theme was the conceptualization of trauma through a developmental lens. Participants conceptualized trauma by viewing the effect of a trauma event on a developmental spectrum, therefore conceptualizing trauma as “understanding how people’s developmental factors affect their understanding of trauma and how it affects personality later.” Multiple participants also differentiated trauma into separate categories. For example, one participant responded to this question by differentiating between trauma from one specific event such as an instance of abuse or a car accident, and complex trauma conceptualized more in relational terms, “more over a span of time.”

Countertransference

The Physiological Responses to Trauma Questionnaire asked participants to respond to the following questions about Countertransference: (a) How do you conceptualize the idea of Countertransference? (b) Do you use the concept of Countertransference in your practice, and if so, how? (c) How do you feel working with trauma survivors affects you personally or professionally?

Participants' responses to the first question, "how do you conceptualize the idea of Countertransference?" were diverse. Responses were analyzed to contain six themes: (a) Countertransference as a response. Multiple participants described Countertransference as an emotional or mental reaction to an individual's emotions, or as one participant put it, "emotional communications;" (b) Countertransference as information. The largest amount of data within participant responses to this question fits into this theme of Countertransference as information. Participants discussed Countertransference as a source of information about clinical data. For example, "how the client is feeling." Others discussed it as information about what both the client and the therapist herself is experiencing, and about the interaction between the therapist and the client. For example, one participant responded, "Countertransference has to do with who I am and where I come from and also the client and where they come from and the space that we make together." Similarly, several respondents used language to describe Countertransference such as "between" [the client and therapist], "back and forth," and "dance." Multiple clients conceptualized the concept as information about the therapeutic relationship; (c) Countertransference as described by certain inherent characteristics. For example, Countertransference was described as "unconscious and nonverbal," "both verbal and nonverbal communication," "a psychic phenomenon," "ubiquitous;" (d) Countertransference as a clinical

tool. Participants discussed Countertransference as a tool that informs clinical action, for example, by allowing therapists to use their feelings to judge how to respond to a client. One participant responded that Countertransference functions to inform clinicians “how to be constructive with feelings.” Multiple participants also discussed Countertransference as a tool for attunement, or “tuning in to the client;” (e) Countertransference as a feeling reminiscent of an emotion or experience from the therapist’s past or background. When Countertransference was discussed in this way, it was discussed as a barrier to a therapist’s effectiveness in working with an individual’s presenting psychological issues; and (f) Countertransference as communication. Several participants discussed this theme in conceptualizing Countertransference. It was described as both verbal and nonverbal communication. It was conceptualized as communication from the client, and also from the clinician’s experience. It was conceptualized as communication from both the client and therapist.

The second question under the category of Countertransference was, “do you use the concept of Countertransference in your practice, and if so, how?” In analyzing participants’ responses, the themes were multi-faceted and diverse. Of the themes indicated, analyses found there to be seven frequently indicated themes: (a) Use of Countertransference as a guide to what is being communicated non-verbally within the session; (b) Use of Countertransference as an indicator of therapeutic issues; (c) Use of Countertransference as an indicator for diagnoses/assessment, specifically with personality disorder diagnoses; (d) Use of Countertransference to inform assessment and intervention; (e) Use of Countertransference as a clinical intervention. There were multiple examples within participants’ responses of the use of Countertransference by “bringing it into the room,” or using CT with the client directly by explaining how the therapist felt in the moment; (f) Use of Countertransference to inform

therapist of client's defenses, and of client's internal experience of affect. For example, one participant discussed that they use Countertransference "to inform me of what is happening internally with the client;" (g) Three respondents discussed using their Countertransference for screening purposes, and in the selection of clients; and (h) Countertransference as an indicator that the therapist needs supervision on the case.

In responding to the third question, "How do you feel working with trauma survivors affects you personally or professionally?" responses were analyzed to include the following themes, divided into categories pertaining to "personal effects of working with trauma survivors" and "professional effects of working with trauma survivors."

Responses to the personal effect of working with trauma survivors contained the largest amount of data. Themes were diverse. Analyses yielded eight consistent themes: (a) Increased experience of Countertransference; (b) Increased feelings, such as, or similar to "anxiety," and "curiosity" or "fascination." In this example, participants did not describe these feelings as Countertransference; (c) Increased positive affect, increase in personal feelings such as "gratitude," "privilege," "appreciation" or "a sense of challenge." One participant responded to this question by noting they experience "increased appreciation for life;" (d) Negative effect on therapist's physical health. Participants used phrases like "secondary exposure," feeling "more stirred up" as well as physical symptoms such as feeling sick to the stomach, or "I feel it in my body, I feel things in my gut, viscerally." This theme also contains two responses in which participants discussed that work with trauma survivors negatively affected the way they modulate feelings of emotional pain; (e) Increased need for therapist to practice self care; (f) Six out of the eight participants discussed that working with trauma survivors affected their personal relationships. For example, one therapist discussed the effect it had on the relationship with their

children, and on their parenting style. Another participant discussed the effect of the work on their intimate relationship with their partner, including decreased desire for sexual interaction. Similarly, several participants' responses discussed the effect of the work on their social interactions, interpersonal boundaries and interactions and ways of communication. For example, "I'm more attuned to trauma and to detecting it in others in my personal life;" (g) Personal effects vary between individual cases. Multiple participants responded to this question first by stating that they do not differentiate between "trauma survivors" and other clients. For example, one participant stated they "differentiate between individual's personality and how unstable or fragmented it is, rather than just if they have experienced trauma." Included in this theme was the concept that "trauma varies, person to person, and not all trauma survivors are the same, therefore my response will also vary;" and (h) Increased negative affect when the variable of suicide exists in therapy. Two participants described that when working with clients who are assessed to be a higher suicide risk, they experienced increased feelings such as stress and fear.

Overall, there was more data collected pertaining to the effects on working with trauma on therapist's personal life, rather than their professional life.

Responses to the effect of working with trauma survivors on participants' professional life contained the following themes: (a) Negative effect of "secondary trauma," "burn out," "fatigue" on therapist's professional practice; (b) Directing the management of case loads. Participants described managing their case loads to contain diverse population in terms of trauma acuity level, in order to manage the amount of trauma cases the therapist can tolerate for mental and physical health and "burn-out." One participant responded to this question by stating, "I kind of titrate my case load, in that I don't see everyone at once who has experienced horrific trauma;" (c) Increased need for support and supervision for therapist and the effect of this on

therapist's finances and time schedule; and (d) Increased ability to assess for trauma in clients and to use proper intervention, also described as increased attunement. Included in this theme is the response that working with trauma survivors increased the participant's effectiveness as a supervisor.

Physiological Response

The Physiological Responses to Trauma Questionnaire asked participants to respond to the following questions about physiological response: (a) Do you include physiological responses in your concept of Countertransference? (b) If yes, what do you include in your concept of physiological response? (c) How do your physiological responses to clients play a role in your work with trauma survivors?

The first question was, "Do you include physiological responses in your concept of Countertransference?" All participants responded "yes," and moved directly into responding to the second question. It is important to note that multiple participants responded to this question by stating that they do not separate physiological experience from emotional experience.

In responding to the second question, "If yes, what do you include in your concept of physiological response?" responses were analyzed to contain six themes. The themes were diverse and multi-faceted. Themes included: (a) Body as communicator: multiple participants responded to this question by discussing a view that countertransferences can be signaled physiologically. One participant stated, "Our minds and bodies can be communicators," and another discussed physiological response as part of "an array of countertransferential resonances, countertransference can be triggered somatically, emotionally or psychically;" (b) Description of specific physiological examples. Examples of specific physiological responses were diverse, including examples such as "stomach clenched" and, complementary to this example, "feeling

physically steady.” Examples of physiological countertransference such as “muscle tension” and “musculo-skeletal tension” were common. One participant described, “not wanting to eat or drink after a session” and “heaviness in my gut.” Other examples were “tearing up,” increased feelings of warmth. Multiple respondents discussed physiological responses felt in the area of their chest: “tightening,” “constriction,” “a pushed feeling,” and “chest area stuff.” Also described were “yawning” and “dreams,” related to therapeutic material or to client. “Tingling in my hands,” “my body feeling more anxious and tense,” “I feel sort of churned up, more speeded up;” “more fidgety,” were other responses; (c) Feelings of fatigue and depression: this theme was reported by several participants; (d) Decreased body awareness. Within this theme responses included therapists feeling numb in their bodies, or discussing “a loss of body awareness,” or “a kind of sense of numbness, occasionally, especially when hearing about an especially physically painful trauma.” Multiple respondents discussed decreased attunement to their physiology, “I kind of feel less attuned to my body, not depersonalized, not de-realized, but just you, know, weird;” (e) All physiological response included in concept of countertransference. Three participants discussed that they do not exclude any physiological response from a concept of countertransference. “The way I think about things is it is all physiology, my eyes my ears my sense of my body, I don’t even know how to talk about what I exclude.” Included in this theme are responses that discussed therapists’ physiological responses as “implicit.” One participant responded,

If this is implicit, you do a little bit of violence to it, by getting too analytic about it...it is more a matter of surfing with it [therapist’s physiological response], tuning your set somehow, but not coming up with pronouncements or mashing some theory on top of this very human experience; and

(f) Difficulty in separating physiological response from emotional response. Three participants included in their response to this question their difficulty in answering it, for example, one participant stated, “it is hard for me to separate out a bodily feeling from an emotional feeling.”

The third question pertaining to physiological response was: “How do your physiological responses to clients play a role in your work with trauma survivors?” Participants’ responses were analyzed into seven themes. The themes were as follows: (a) To inform therapist of clinical material. Discussion of the clinical material included examples of material from both the client and the therapist, from only the client, or from only the therapist. Some examples of how physiological response informed participants of clinical material are: the physiological experience the participant felt was seen as “the physiological response the client is having,” “informing me of where the client’s ego might be stuck.” There were multiple responses that discussed therapists’ physiological responses informing the therapist of the client’s internal emotional experience. One participant called their physiological response, “a kind of naturalistic mirroring,” and “an indicator of all the different levels at which someone may be feeling, what they may be talking about or going through;” (b) To inform therapist’s clinical assessment and intervention. Multiple participants discussed ways in which their physiological responses informed their assessment of trauma survivors as well as how they would respond to their clients clinically. One participant responded:

The mind ego comes from the body ego so then to trace it back to these tendrils of body ego growth to help them grow forward to be mentalized. Usually that happened in the mind and body of the therapist or analyst before they reach fruition in the patient, because of their trauma of course.

Similarly, multiple participants discussed using their physiological responses to inform assessment by describing that their physiological experience communicated when a client was “stuck.” Within this theme are included responses in which participants discussed their use of their physiological response to assess a client’s “defenses.” For example, participants responded that they use their own physiological responses in assessing when individuals were “guarded,” and “about their story, about their experience of affect or emotions;” (c) No differentiation between trauma/non-trauma clients. Two participants responded to this question by clarifying that they hold a “broader” definition of trauma, stating that conceptually they do not differentiate between trauma/non-trauma clients in their practice and therefore don’t use their physiological responses any differently with trauma survivors than with “non” trauma survivors. One participant said, “In terms of physiology, I use it with everybody I work with, so I use myself in my response to my patient, I don’t have this separate category for trauma;” (d) Informing clinical action with trauma survivors who present with suicidal ideation or are a suicide risk. Multiple participants referred to the variable of suicidality, stating that they are more aware of their physiological responses with this population. Participants said in these cases, their physiological response allowed them to make decisions about how to respond appropriately. For example, one participant described how their physiological responses informed their clinical action, and allowed them to “keep the therapy going.” Another participant spoke about being aware of feeling angry, or fearful with a suicidal client and they used their physiological response to inform them of how to respond in a way that would “keep the treatment going, not to fire her, not to be fired by her. That kind of thing, go home with a clear conscience. It does feel very life and death, especially with a suicidal person;” (e) To practice mindfulness. One participant discussed the use of their physiological response as part of utilizing mindfulness as a clinical intervention

with trauma survivors. “I find that using mindfulness is really helpful and it usually comes up as part of that;”(f) As an indicator of where client is viewed developmentally. Multiple participants discussed “stuckness,” or where they viewed the client developmentally in terms of processing the traumatic event or experience. “Stuckness” was a word used frequently in responses to this question. One participant elaborated:

Like when I’m feeling more keyed up its when they are taking me with them, almost like they are taking me to a scary place with them, but sometimes they don’t really take me, and then I don’t feel as stirred up, but I feel more sad for them because I feel like it is an indication that they are more stuck; and

(g) As an indicator of how open a client is to therapy, or as an indicator of how much the client had processed the trauma. One participant used the following example to describe a time they felt increased physiological response, and how they used it:

When they are just going round in a litany of rage that you know they’ve been through a hundred times, and it seems more like traumatic encapsulated memories where they are not open to intervention or sharing or really, it is more a recitation. Then I feel more discouraged.

Case Examples of Emotional and Physiological Countertransference

Participants were asked “Tell me about a time that you were aware of: Emotional Countertransference and Physiological Countertransference.” In responding to the first part of the question, “Tell me about a time that you were aware of Emotional Countertransference,” participants’ responses were analyzed to contain seven themes. The themes were as follows: (a) Description of Countertransference contained feelings of hurt paired with a sense of protest; (b) Desire to align with client: data within this theme included participants’ use of phrases like

“collude with client” or “cheer on client;” (c) Describing both Emotional and Physiological responses in description. Two participants responded to this question by describing both their emotional and physiological responses to a client, together; (d) Description of Countertransference containing feelings of anger or rage about circumstances of client’s life, or about the therapist’s world concept; (e) Experience of difficult, intense affect such as “terrified,” “threatened,” “frustrated,” “loneliness,” “fear;” (f) Participant stated explicitly they do not distinguish between emotional and physiological Countertransference. One participant responded to this question by stating, “I don’t make a distinction between the two, emotional and physiological, that doesn’t make sense to me;” and (g) Sexual Abuse. Three participants used examples of emotional Countertransference when working with survivors of sexual abuse. Moreover, their reactions were commonly described as feelings of anger. For example, one participant described feeling fear in anticipation of hearing about disturbing material about sexual abuse.

In response to the question, “tell me about a time that you were aware of Physiological Countertransference,” participants’ responses were analyzed to contain diverse themes. Analysis yielded eight frequent themes: (a) Description of both emotional, rather than physiological response. Two participants responded to this question by describing feelings and emotions rather than physiological responses. For example, “those both brought up feelings of my being dirty and disgusting, and invasive and a terrible guilt about that and also a sense of not being understood.” In these instances, when asked to elaborate on their physiological response, participants struggled to describe their physiological response. For example, following the above response, the participant said, “kind of feeling disgusting, physically, it just kind of permeated me a bit;” (b) Physiological response interpreted as anger. This theme included descriptions of

physiological responses that the participants interpreted as “anger.” Physiological responses that indicated anger included, “stomach clenching,” or “I had to really almost sit on my hands because I felt so angry;” (c) Example included therapist using their physiological response to inform them of client’s “transference.” For example, one participant responded, “I was acutely aware of instantly feeling this rage, that didn’t feel like it was fully mine, and yet I was the one feeling it;” (d) Example of attention to heart rate and breathing. For example, change of rate of breathing, increased or decreased. Multiple participants described “my heart beating faster”, “head throbbing,” “feeling flushed;” (e) Example of feeling disconnected from the physical body and from the breath. For example, “Like in my body, I feel like I’ve left;” (f) Physiological response viewed as a form of “perception.” Multiple participants discussed their physiological response as a way of perceiving their client, which informed their clinical action in the moment, i.e. safety, client’s dangerousness. In one participant’s words:

But this person made me very uncomfortable, and I wasn’t comfortable seeing him. And I ignored my own, this wasn’t just countertransference, it was really basic. I ignored my own perceptions...he was also escalating and very dangerous and I sense that I should have trusted my own.

(g) Sexual Abuse: two clients used examples of physiological countertransference that they experienced while working with survivors of sexual abuse; and (h) One participant responded to this question by describing that they do not have a physiological response without an emotional response.

Interaction of Emotional and Physiological Responses in Clinical Work

Participants were asked the question, “Do you believe emotional and physiological Countertransference are linked, and if so, how are they linked?” Five participants responded,

“yes,” that emotional and physiological Countertransference are linked. One participant said, “I’m not even sure I’d say they are linked, I’d just say they are all different aspects of a person’s experience.”

Of the participants who responded, “yes” to this question, there was an array of diverse themes that surfaced. Analysis yielded four common themes: (a) They are linked unconsciously. For example, “It is largely unconscious, until you have to write about it or talk about it;” (b) Emotional and physiological countertransference work together to inform therapist about their client.

Emotional and physiological cues [in the therapist] tell them something doesn’t fit, it is a correlation. I think that the more we can integrate all of our perceptive lines, the better understanding we’ll have of our clients and of ourselves.

Similarly, another participant discussed using physiological and emotional response together, to inform therapist about the meaning of the trauma for the client. “For clinicians to be able to get on the wave length, to bring new meaning to what was meaningless as a trauma;” (c) Emotional and Physiological responses are linked by therapist’s awareness. Multiple participants discussed that “awareness” is the key to understanding how Emotional and Physiological responses are linked. One participant stated,

I think that they are linked, and I think if we are present in our body, we will allow them to be linked. If we are not, we are going to disavow that there is a connection. I think we’re going to see it, or let ourselves see it, that there is a connection. I can’t imagine that they are separate.

Another participant stated, “I know from my experience that they are not separate, it is just a matter if you are aware of it, and there is something happening.” Finally, in valuing participants’

actual responses, another participant stated, “I think that it is physiological, the whole sequence, it is fundamentally experiential and physiological;” and (d) Linked based on conceptualization of individual as “whole being”. Included within this theme are responses that described the individual as informed by emotional, cognitive and physiological experiences that affect each other. Multiple participants discussed their beliefs that these ways of experiencing are linked, and that they conceptualize individuals in this way. “They are linked the same ways the emotions and the body are always linked, you know that I don’t see how they could not be linked.” Similarly, “I guess I hope they are linked in that we listen to the physiological cues as part of our understanding of the client.”

Chapter V

Discussion

This exploratory-descriptive study examined the research question, how do therapists use their physiological responses in work with trauma survivors? The research question was explored from the perspectives of eight Relationally oriented therapists who worked with trauma survivors. The Physiological Response to Trauma Questionnaire was utilized by the researcher to explore how participants' physiological responses and concept of countertransference interact with clinical functions, specifically with therapists' ability to attune, choice of interventions, assessment, and ability to maintain boundaries and prevent vicarious trauma. Broadly, the study sought to understand how a therapist's physiological responses play a role in how they construct meaning about a client.

In this chapter the findings from this study will be discussed in relationship to the broad themes of: therapists' ability to attune, choice of interventions, assessment, and ability to maintain boundaries and prevent vicarious trauma. The findings of the study will also be discussed in relationship to each other and to prior knowledge.

Attunement

The findings illustrate that participants viewed countertransference as a tool that functions to increase attunement within the therapeutic milieu. Examples include descriptions by participants that countertransference functions to inform therapists of "how to be constructive with feelings," and as a tool for "tuning in to the client." This is not congruent with the earlier

literature from Pearlman and Saakvitne (1995) and later from Pearlman and Caringi (2009) that proposed that CT and vicarious traumatization can challenge therapists' ability to attune to clients' needs and to their ability to create the empathic engagement necessary to form an authentic therapeutic relationship. The exception to this was one participant who viewed countertransference as a barrier to effectiveness, and as reminiscent of a feeling or experience from the therapist's past or background.

Therefore, findings illustrate that participants' conceptualization, use and awareness of countertransference play roles in their ability to attune to clients. Following this, participants revealed unanimously that they include their physiological responses in their conceptualization of countertransference, and described countertransference as both verbal and nonverbal communication. This illustrates that participants see their physiological responses as playing a role in attunement in therapy. Specifically, for example, this is illustrated in multiple responses that discussed therapists' physiological responses informing the therapist of the client's internal emotional experience. As stated previously, a participant described their physiological response as, "a kind of naturalistic mirroring," and "an indicator of all the different levels at which someone may be feeling, what they may be talking about or going through." Therapists used their physiological response as a "communicator" for their countertransference, they used body awareness as a therapeutic tool. The clinical issues that arose in the findings are categorized into the broad theme of clinical attunement.

These findings lend validity to Surrey's (1997) discourse on the role of mutuality in attunement. While participants did not use the term "mutuality," their responses reflect Surrey's (1997) description of mutuality as a therapist being empathically attuned, emotionally responsive, authentically present, and open to change. Surrey (1997) is linking the presence of

mutuality to attunement, assessment, and arguable, appropriate boundary making. The findings build on this literature by illustrating the role of Relational therapists' physiological experience in achieving mutuality, thus linking therapists' awareness of their physiological responses to clinical functions like attunement.

Choice of Interventions

Examining participants' responses within the theme of "choice of intervention" led the researcher to the complex question of, "what factors inform therapists' choice of intervention with any particular client?" The findings illustrate that participants' attunement to clients' internal emotional state, to the clients' level of trauma, to the clients' perceived openness to therapy all play roles in how the clinician determines to intervene. Findings illustrate that "choice of intervention" describes therapeutic action in the moment, whether it be with minute therapeutic interaction or in a therapist's broader choice of treatment. Participant responses are congruent with Orange, Atwood, and Stolorow's (2001) proposition that a focus on intersubjectivity informs a therapist's determination of what approach is appropriate with a particular client. Examples of this include descriptions of countertransference as a tool that exists "between" [the client and therapist], that is a "back and forth" dynamic and its conceptualization as a "dance" in which the therapist's awareness is key. These descriptions can be linked to Orange et al.'s (2001) descriptions of the intersubjective space and to the role of intersubjective awareness in the clinical function of assessment, and choice of intervention. As it has been stated that each participant met criteria in practicing Relationally; they also described their orientation to include diverse therapeutic frameworks. It is evident that in light of the diversity of orientations, there was also a common conceptualization, or focus on the intersubjective space.

Within this theme are included responses describing countertransference as a tool that informs clinical action. The use of countertransference as a clinical tool was explicitly stated by multiple participants. Also included is the theme that a therapist's felt countertransference was used as an intervention by "bringing it into the room." These findings illustrate that participants not only use their concept of countertransference to inform their use of and choice of therapeutic interventions, they also use their felt experience of emotional and physiological countertransference as an intervention in and of itself.

Assessment

Examining participants' responses within the theme of "assessment" led the researcher to the complex question of, "what factors inform therapist's assessment of a client?" Also contained within this theme is the concept of how a therapist constructs meaning about a client.

Participants' responses indicate therapists' use of countertransference as an important tool that informs them of therapeutic issues, such as use of or awareness of affect in a client. Findings show that countertransference, including physiological response, inform assessment. One response illustrates the use of countertransference including physiological response as a clinical tool:

For me it is non-verbal, when I can pay attention to that and keep it separate from my own anxiety about it, or my own stuff, it is really helpful. It gets you right to it; it goes right to the heart of it really. And for me I use that in my practice and it is hugely helpful. The way I think of it is that it is just pure amygdala to amygdala communication, and part of what we are doing is somehow having the connection where we are sharing the experience to some degree and I think that I use it more to inform, it informs me about

what my client's experience is, and what I'm going to do with that. So, I guess every minute is assessment; every minute is an intervention, so I don't really split those out.

Similarly, findings illustrate the use of countertransference in assessing for diagnoses, specifically with personality disorder diagnoses. This lies within the category of assessment. In addition, participants described the use of countertransference for screening purposes. The findings indicated that therapists' experiences of countertransference alerted them to diagnoses of personality disorders, however, responses did not elaborate on specifically what these countertransferences were, or the type of physiological response the therapist experienced that informed the assessment of a personality disorder diagnosis. Responses also indicated this type of experience was then used for screening purposes. Participants discussed the use of countertransference to inform their assessment and intervention (assessing for suicide, increased fear or anxiety, feeling something different and using it to assess). The literature review for this study did not find prior literature discussing the interaction of the variable of a client's suicidality with the therapist's countertransference and ability to assess.

Ability to Maintain Boundaries and Prevent Vicarious Trauma

Data pertaining to the themes of therapists' ability to maintain boundaries and prevent vicarious trauma were collected from participants' responses to the question, "how does working with trauma survivors affect you personally and professionally?" Findings illustrate that participants believe work with trauma survivors increased their countertransference, and also increased negative affects on their physical health. Findings also illustrate that therapists experienced greater awareness of their physiological response with trauma survivors, including an increase in negative affect. The link between findings and previous vicarious trauma literature was illustrated by the use of phrases such as "secondary exposure" and "more stirred up."

Similarly, findings illustrate that participants believe working with trauma survivors increased therapists' need to practice self care. This indicates that in working with a population of trauma survivors, therapists used stronger boundaries as related to affect, perhaps in order to minimize experiencing negative emotions or physiological responses such as anxiety, fear or tightness in their chest.

The majority of participants discussed that this work affected their personal relationships, similarly indicating the use of using countertransference and physiological response to screen for clients with whom boundary setting would challenge the therapist, or in which the therapeutic work would indicate increased possibility for vicarious trauma. Additionally, findings show therapists felt increased stress and fear when the variable of suicidality was added to trauma work. These findings inter-relate, as the experience of vicarious trauma, including fatigue, depression or decreased physical health, was shown to effect personal relationships. The use of physiological and emotional countertransference was used as a tool to inform therapists of how to screen and "titrate" their caseload to prevent or reduce their experience of vicarious trauma. Overall, the use of countertransference for screening purposes, in particular for clients with personality disorder diagnoses, and who are assessed as suicidal, informed participants' experience of their awareness and capability to set inter-personal boundaries in order to protect themselves from experiencing vicarious trauma. Also, in order to use boundary setting as a self care practice.

Findings related to the effect of working with trauma survivors on participants' professional life convey issues of vicarious trauma and boundaries as well. A frequent theme was explicitly, "secondary trauma," "burn out" and "fatigue." The discussion of managing and screening caseload to "titrate" the amount of trauma a therapist worked with functions as

boundary setting. Similarly, the finding that countertransference was utilized as an indicator that the therapist needs supervision on the case illustrates the use of physiological response in boundary setting.

Conceptualization of Trauma

The diverse responses gathered from participants about their conceptualizations of trauma illustrate the complexity of how therapists define “trauma.” The range of responses indicated that regardless of a therapist’s orientation, their conceptualization of trauma was unique. Following this, the data indicates that a therapist’s assessment and choice of intervention will be directly related to their unique conceptualization of “trauma” and the effect of “trauma” on a client’s sense of self, their ego, or the client’s defenses, for example. Findings did not directly corroborate this study’s conceptualization of trauma as an individual’s experience of unbearable affect, and as understood in terms of the relational system from which it emanated (Stolorow & Atwood, 1992). Some responses corroborated this conceptualization, for example the use of words like “overwhelming” to describe the effects of trauma, and also in the conceptualization of trauma through a developmental lens. This illuminates the issue of divergent conceptualizations amongst practitioners who practice within the same framework, in this case Relationally. It must also be acknowledged that while each participant met the inclusion criteria of practicing from a Relational orientation, each participant also listed numerous other orientations from which they functioned clinically. Operationally, the data illustrates that each participant offered a unique take on the definition of trauma and in the clinical use of the concept. This illustrated marked differences in clinical factors such as choice of intervention and assessment.

Findings illustrate that within the study a therapist’s appropriate assessment of trauma and of proper therapeutic intervention hinges on their awareness of the intersubjective field and

on the client's developmental history and conceptualization of current placement developmentally. More specifically for this study, appropriate assessment hinged on a therapist's understanding of a concept of countertransference, or the dialectic between their own subjectivities, and that of the client. It is seen that amongst a population of Relational therapists, their awareness of physiological response plays a key role in attunement, which illustrates the role of a therapist's physiological response within the dynamic process of the therapeutic relationship.

Countertransference

Findings illustrate that while participants did not use the term "mutuality" within their conceptualization of countertransference, their responses to this question mirrored Surrey's (1997) description of mutuality as a way of being emotionally responsive, empathically attuned, authentically present, and open to change in the therapeutic relationship. The findings indicate that participants' descriptions of the characteristics of countertransference and their conceptualization of countertransference as a tool and as information, reflect an awareness and utilization of Surrey's concept of mutuality. The consistent themes of countertransference as a response, as information, as a tool, and as communication, indicate that participants explicitly work towards awareness and a utilization of countertransference in their therapeutic work with trauma survivors. Furthermore, findings show that participants believe an awareness of countertransference increases their ability to attune and informs their assessment and choice of intervention. An awareness of countertransference also affected the ability to maintain boundaries and prevent vicarious trauma or "secondary trauma." Participants endorsed data that fit into each of the four categories of clinical functions listed above. Most prevalently evident

was the theme of countertransference as increasing a therapist's ability to attune and to be used in assessment and meaning making.

In responding to the question pertaining to the personal effects of working with trauma survivors, participants' responses corroborated the work of Hayes and Gelso (2001) that cited the positive effects of the work with trauma survivors. For example, participants focused on the "gratitude" and the "sense of challenge" they feel from the work, rather than focusing on the impediments that occur through the use and management of countertransference reactions. Overall, participants discussed their use of countertransference in therapy as positive and constructivist, adding to the literature that calls for focus on the role of their self-experience in therapy, and on how therapists' self-awareness functions within an understanding of CT (Hayes & Gelso, 2001). While countertransference experiences with trauma survivors were described as physically and emotionally uncomfortable, findings indicate the population conceptualized the role of the therapist as a willing participant in experiencing the countertransference and utilizing it to collaborate and connect with the client in the therapeutic process.

Findings illustrate a conceptualization of countertransference to include both the client *and* the therapist's material. This corroborates the Relational perspective of countertransference as a dynamic process in which the therapist attempts to take part in and gain awareness of the dialectic between their own subjectivity and that of the client. Mitchell (1988) and Benjamin (2004) proposed a psychoanalytic framework that views the individual as understandable within relationship, and the relational field as being created by both the client and the clinician's subjective internal experiences. This view was also evident in the data. For example, one participant stated that in viewing their countertransference, rather than asking themselves what the client needs, they questioned, "what does this relationship need?" Viewing responses through

this lens, the findings illustrate diverse levels of awareness and capacity of participants to describe the subtle, intersubjective interactions that occurred with their clients. While each participant indicated that their physiological response was implicitly or explicitly involved in communication, attunement and assessment, some descriptions of their physiological responses and the interaction of the physiological with the cognitive and emotional experience were more in depth than others. This variance could indicate varying levels of adeptness to describe conceptualizations, or varying levels of awareness of either physiological or emotional countertransference.

Findings from the section of the data tool inquiring about the link between emotional and physiological countertransference corroborate with Knoblauch's (2005) discourse on the construction of meaning in relational analysis. Participants' responses indicate a struggle to verbalize their beliefs and experiences of the interaction of the emotional and physiological, or perhaps to make explicit the implicit. This qualitative data adds to the foundation of literature that has begun to elucidate how therapists construct meaning about their clients and the role of physiological and implicit communications within the therapeutic interaction. Evocatively, in response to this question, multiple participants appeared to be at a loss for words. Knoblauch (2005) discusses the limitations of language in providing accurate symbolization for a client's experience, and proposes incorporating nonverbal embodied communication in addition to language, as a gateway into the unconscious meaning in therapeutic action. Here, this lens could also be applied to the therapist's experience. As one participant put it:

If this is implicit, you do a little bit of violence to it, by getting too analytic about it...it is more a matter of surfing with it [therapist's physiological response], tuning your set

somehow, but not coming up with pronouncements or mashing some theory on top of this very human experience.

In reference to Bennett's (2008) work elucidating the role of attachment style in therapeutic interactions, the results of this study did not address this topic. While participants did not discuss the topic of attachment within the therapeutic relationship, the findings that illustrated the notion of the impact of development, personality, sense of self and ego within the concept of countertransference could be viewed as part of Attachment Theory.

Physiological Countertransference

It has been previously discussed that the findings of this study illustrate a conceptualization of countertransference that contains not only the affective ideational responses a therapist has with her client, but also her physical responses. The study has used the term physiological countertransference. This corroborates Pearlman and Saakvitne (1995) view in directing the literature toward including a therapist's physiological responses in an understanding of countertransference.

Much of the past literature on somatic countertransference is also corroborated by the findings of this study. Multiple responses from participants are evocative of Eagle's (1993) conceptualization of a "corrective emotional experience" in therapy resulting from implicit communications and interpretations between client and therapist, which have a correctional function for the client. Viewing the transference-countertransference interaction through a lens that includes implicit or non-conscious communication, it is possible to place physiological experience in this subtle interaction. This is well illustrated in one participant's response:

I think that psychoanalysis or psychotherapy, or whatever you want to call it, is done best when it is intensely experiential, when it goes through thoughts and cognitions all

the way down to the emotional implied level, and it is just a matter of having our experiential set tuned to apprehend that stuff, as intimately and intuitively as possible and then being able to take that and then give it back to the person, intimately and intuitively. I think that it is physiological, the whole sequence, it is fundamentally experiential and physiological.

This response corroborates Eagle's (1993) conjecture that communication need not be explicit in order for it to function therapeutically. It illustrates that the use of therapist's physiological response being viewed as paramount to creating a correctional emotional experience in the therapeutic setting.

Findings did not indicate that participants used countertransference or physiological response in identifying biases, maintaining ethical standards, or to work towards the elimination of social injustices such as racism. Responses did not contain data on these themes. The data tool did not contain questions pertaining specifically to these themes, which might have played a factor in the lack of data on the topic.

While there were diverse themes with some frequency, the results of this study corroborate the past literature, which has shown that various conceptualizations and contradictory meanings can be applied to terms such as countertransference or to trauma. Similarly, past research and literature exploring the physiological aspects of countertransference have used various terms and applied contradictory meaning to the concept of physiological response. Aspects of therapists' physiological experience of countertransference have been named somatic countertransference, body-centered countertransference and embodied countertransference. During the data collection process the researcher used both the terms "physiological responses" and "physiological countertransference," and the findings illustrate a

familiarity of these terms amongst participants as well as divergent uses and conceptualizations of each.

In comparing findings to previous Somatic Countertransference literature, the diverse responses captured in the study indicate that even within a small population, conceptualizations of psychological terms are unique amongst individuals. Responses contrasted to Field's (1989) work in that they described therapists' physiological responses as related to the client's material rather than as unrelated or in contradiction to the client's manifest material. The majority of the findings indicated agreement with the more contemporary literature, reflecting the concept of Body-Centered countertransference as the therapists' awareness of their own body, of sensation, images, impulses, feelings and fantasies that offer a link to the client's process and to the intersubjective field (Vulcan, 2009). Findings are also convergent with the recent somatic countertransference literature in viewing countertransference from a Relational lens, with an emphasis on the use of intersubjectivity (Vulcan, 2009; Long, 1999; Wilson, 2004).

Overall, in comparing the findings to the past literature on somatic countertransference, participants' responses tended to be congruent with Vulcan's (2009) work, which described the therapist as an active participant whose somatic responses are part of the therapeutic interaction. Participants viewed physiological countertransference within a Relational framework, illustrating a view of therapists' experiences and use of physiological responses during therapy with trauma survivors as experiences of what the literature calls "somatic countertransference". At this time it is again important to note that all the participants identified as relationally oriented, however, they also identified as working from multi-faceted therapeutic frameworks.

Summary

This study sought to build on past research and to further explore the topic of therapists' management and use of their physiological experiences in clinical interactions. It was an examination of the implicit communications that exist between client and therapist, between the therapists' body and conscious mind; between implicit communications and explicit meaning making. The literature illustrates that the relationship between the emotional and physical is not well understood, and the findings of this study certainly add to prior work. At the same time the findings illustrated that therapists are increasingly aware of their physiological responses within the therapeutic environment, and they are using their physiological experience as an important clinical tool. There are connections to be made between therapist's physiological experiences and the interaction of that experience with the construction of meanings in therapy. The construction of meaning is at the foundation of the concept of attunement, and the clinical issues of assessment and choice of interventions. Informed by early relational theorists like Stolorow and Atwood (1979), this study was similarly concerned with the subjectivity of psychological knowledge and the use of universalized metapsychological concepts such as "countertransference" in the therapeutic setting.

Limitations of Study

Although this research study contributes to existing literature regarding countertransference and trauma, and somatic countertransference, due to the small sample size generalizability of the findings to the larger population is limited. There were limitations in terms of participant recruitment, due to time constraints.

Also, it is acknowledged that because the majority of participants were recruited from a psychoanalytically based organization, they represent a particular perspective in terms of how they viewed psychological concepts such as countertransference.

It is also important to note that participants were all well educated, predominantly upper-class, middle-aged, and Caucasian. A sample containing a population of more racially, ethnically and socio-economically diverse participants would have the potential to produce more representative data, in terms of the articulation of subjective opinions and themes, which could be generalized to a diverse larger population.

Implications for Practice

The findings of this study illuminate multiple important themes for mental health professionals. Broadly, for therapists to maintain a sophisticated level of awareness of their own subjectivities and to find perspective on how these subjectivities might be translated into psychological conceptions and hypotheses, and into the larger category of clinical meaning making.

A vital finding was the role of the therapist's physiological response in clinical issues such as attunement and assessment. This finding may highlight to practitioners the role their physiological responses play in the therapeutic realm, and the possibility that the therapist could make good use of increased body awareness. Greater awareness of physiological response and the role it plays in individual construction of meaning could be of clinical use in therapist's further exploring their concept of countertransference, and gaining perspective on the role of their subjectivities in their therapeutic relationships and the communications therein. Clinically, bringing body awareness into the therapeutic interaction brings another level of attunement to the intersubjective space and the non-verbal or implicit communications that research is beginning to

illustrate are ever-present between individuals. Increased awareness of yet another subjective experience may lead to increased attunement, more accurate assessment, and an increased ability to create appropriate boundaries and facilitate self care.

Clinicians should take into account the finding that physiological response plays a role in the foundational clinical aspects such as attunement, so they can be aware of how their own reactions to, or experiences of the body might interact with their ability to be present, or, conversely, to resist, ignore, or avoid.

Finally, an implication of this study is for the education of mental health professionals on the topic of body awareness. The findings of this study beg the question: “is there a responsibility for therapists to build awareness of their bodies, to increase attunement to their own physiological experiences in order to possess a greater awareness of the implications of their physiological experiences and implicit communications within the therapeutic context?” Considering an intersubjective foundation of psychology, clinicians must go deeply into their own subjectivities, including their physiological experience, in order to engage with a conception of another individual’s human nature. Findings illustrate that clinicians are using their physiology as a clinical tool; the implications of this are for collaboration and education on how to utilize physiological experience ethically and constructively.

Implications for Research

The aim of future research may be to conduct more in-depth interviewing with a diverse and large population of therapists who practice from a multitude of therapeutic frameworks. This type of sample population might draw out more diverse themes and be further reaching. These methods may allow for the themes to emerge that have yet been unexplored in literature and research.

Further empirical research may also include a sample population being introduced to the variable of training/education aimed to increased body awareness. Both the sample and the control group with no training could be interviewed to explore differing views on universal themes such as countertransference, in efforts to collect data on the effect of the body awareness training.

In reference to the topic of clinical training to increase awareness of somatic countertransference, future research may include studies that explore the effect of trainings aimed to increase therapists' body awareness and body experience through the use of modalities such as movement/dance therapy, yoga, or physical activities such as walking or swimming. Miller (2000) recommended that in order to decrease fear of the body, therapists should explore the link between the body and mind and build insight through self-observation, reading, and monitoring mental responses during body movement or massage. Similarly, clinical education should include training for therapists to be better observers of clients' bodies. Research exploring the effects of this type of education could further add to the discourse on somatic countertransference and its clinical implications.

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Appendix A
Recruitment Flier

‘Implicit Communication:
The Body’s Role in Clinical Work with Trauma Survivors’

A Qualitative Research Study

I am seeking to interview therapists who currently work with trauma survivors, and who practice within a Relational Theory framework. I am interested in exploring how therapists’ physiological responses to trauma survivors inform their ability to attune, choice of interventions, assessment, and ability to maintain boundaries.

Inclusion criteria:

- Washington State or Oregon State licensure as a mental health professional, licensed independent clinical social worker, licensed clinical social worker or psychologist
- English-speaking
- Five or more years clinical practice post licensure
- Current or past therapeutic practice experience with trauma survivors
- Utilize Relational Theory in clinical practice

Please contact Julia Jakubowski

(Smith College School for Social Work Student)

at (personal information deleted by Laura H. Wyman, 11/30/12) if you meet the inclusion criteria and are interested in voluntarily participating in this research study.

Interviews will take place in February and March, 2012, and will be one hour in length.

Participation in this study is completely voluntary and your confidentiality will be protected.

Thank you for your interest!

Appendix B

Informed Consent Form

Dear Potential Participant,

My name is Julia Jakubowski and I am conducting this research study through Smith College in Northampton, Massachusetts, where I am a student in the Master of Social Work (MSW) Program.

I am interested in exploring the role of therapists' physiological responses in their work with trauma survivors. Specifically, this study will look at how physiological responses interact with therapists' ability to attune, their choice of interventions, assessment, and their ability to maintain boundaries. In particular I am interested in a population of therapists practicing from a Relational Theory framework.

The data from these interviews will be used for my MSW thesis and for possible presentation and publication. My study is called: "Implicit Communication: The Body's Role in Countertransference."

The criteria for participation in this study are: 1) Washington State or Oregon State licensure as a mental health professional, licensed independent clinical social worker, licensed clinical social worker, or psychologist; (2) English-speaking; (3) at least five years clinical practice post licensure; (4) current or past therapeutic practice experience with trauma survivors; and (5) utilization of Relational Theory in clinical practice. If you voluntarily agree to be interviewed about your therapeutic experience, we will meet for a one hour-long interview. The interview will take place at an agreed upon time between January-March 2012. The interviews will be audio taped and transcribed.

There is potential for some risk to individuals who participate in this research study. Some participants may experience emotional difficulty when they discuss their therapeutic interactions with trauma survivors. However, it is also anticipated this project will increase awareness about the body's role in countertransference, adding to literature that that will aid therapists in the ethical use of psychotherapy.

Your confidentiality will be protected by the following measures (in compliance with Federal Guidelines):

- 1) No names will be attached to the data or transcripts.
- 2) The tapes of the interviews will be kept in a locked storage box, and will be taken out when they are transcribed by the researcher. Following the study, tapes will be locked in a file cabinet for a period of 3 years and then destroyed.
- 3) My research advisor will not have access to any identifying information on the interview data.
- 4) All Consent Forms will be kept separate from the interview data and linked through a randomly chosen code number.

5) As a participant, you have the right to (a) decline to answer any question, (b) end the interview at any time, and (c) withdraw from the study at any point up until May 15, 2012. If you choose to withdraw from the study prior to this date, all material pertaining to you will be destroyed immediately.

6) When the information is summarized in the research study, responses will be disguised and your real name will never be used.

Please remember, participation in this project is voluntary.

A copy of this form will be provided to you by the researcher, PLEASE KEEP A COPY FOR YOUR RECORDS.

Should you have any concerns about your rights or about any aspect of the study, you are encouraged to call either the researcher or the Chair of the Smith School for Social Work HSR Committee at (413) 585-7974.

Feel free to ask me any questions, and thank you for participating in this study:

Julia Jakubowski,

(personal information deleted by Laura H. Wyman, 11/30/12)

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

Appendix C

Physiological Responses to Trauma Questionnaire

Code Number: _____

1. Trauma

- How do you conceptualize trauma?

2. Countertransference

- How do you conceptualize the idea of Countertransference?
- Do you use the concept of Countertransference in your practice, and if so, how?
- How do you feel working with trauma survivors affects you personally or professionally?

3. Physiological Response

- Do you include physiological responses in your concept of Countertransference?
- If yes, what do you include in your concept of physiological response i.e. crying, blushing, coughing, feeling hot/cold, increased heart rate, stomach aches, headaches, feeling tired, dreams.
- How do your physiological responses to clients play a role in your work with trauma survivors?

4. Tell me about a time that you were aware of:

- Emotional Countertransference
- Physiological Countertransference

5. Do you believe emotional and physiological countertransferences are linked, and if so, how are they linked?

Appendix D
Demographic Information

1. What is your age?

(Age in years) _____

2. What is your gender? _____

3. What is your marital status?

Married Never Married

Widowed Divorced Separated

4. What is your racial/cultural/ethnic identity?

African American American Indian Asian American

Caucasian Latina/o Pacific Islander

Multicultural Mixed Race Other

5. What is your highest level of education?

(Specify degree) _____ (Specify profession) _____

6. Where are you employed?

Private Practice Agency/Organization _____

Other _____

7. What is your annual gross income? \$ _____

8. How long have you been a clinician?

(Specify years) _____

9. What theoretical framework is utilized in your clinical practice?

(Specify) _____

10. Please be specific about what areas of diverse populations you have worked with in your practice (racial/cultural/ethnic identity, sexual orientation, gender, age, marital status, socio-economic status).

Appendix E

Agency Letters of Permission



February 13, 2012

Smith College School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

Oregon Society of Clinical Social Workers gives permission for Julia Jakubowski to locate her research in this agency/institution. We do not have a Human Subjects Review Board and, therefore, request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) perform a review of the research proposed by Julia Jakubowski. Oregon Society of Clinical Social Workers will abide by the standards related to the protection of all participants in the research approved by SSW HST Committee.

Sincerely,

John Milnes

SEATTLE
PSYCHOANALYTIC
SOCIETY AND INSTITUTE

4020 East Madison Street, Suite 230 www.spsi.org
Seattle, WA 98112 info@spsi.org
Fax (206) 328-5879 (206) 328-5315

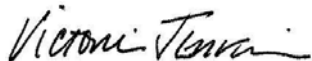
February 7, 2012

Smith College School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

The Seattle Psychoanalytic Society and Institute gives permission for Julia Jakubowski to locate her research in this institution. We do not have a Human Subjects Review Board and, therefore, request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) perform a review of the research proposed by Julia Jakubowski. SPSI will abide by the standards related to the protection of all participants in the research approved by SSW HST Committee.

Sincerely,



Victoria Jenkins
Administrator

Appendix F

Human Subjects Review Committee Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 13, 2012

Julia Jakubowski

Dear Julia,

Very nice work. Thank you for the effort and I am sorry if some of the comments were hard to understand. Nonetheless you responded very well and professionally and we appreciate that! So you are approved and if you use a list serve, please send us a copy of their permissions to you as you go.

Please note the following requirements:

Consent Form: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your research.

Sincerely,

A stylized signature of David L. Burton, consisting of the letters 'J', 'j', and 'J' in a decorative, calligraphic font.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Marian Harris, Research Advisor