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Does our Codependency Help or Harm our Clients?

Codependency and Countertransference

Given the prevalence of codependency in America – estimated as high as 85% - it's a disorder that shouldn't be overlooked in clients, irrespective of their diagnosis or presenting problem. Psychotherapists can also be codependent. In fact, I suggest that some codependency is prerequisite to becoming a therapist, and perhaps even essential to become a good one – for who else would take such pleasure in focusing on helping others – often at the expense of their own needs. Whether a therapist's codependency helps or harms the therapy turns on self-awareness. This article highlights how codependency affects treatment.

Definition and Cause of Codependency

"A codependent is a person who can't function from his or her innate self, and instead, organizes thinking and behavior around a substance, process, or other person(s)." (Lancer, 2012, p. 30) The causes lie in deficient mirroring and attunement to feelings and needs and in family dynamics characterized by denial and dysfunctional rules, boundaries, and communication. For survival, children learn to focus on and accommodate others. They deny or suppress feelings and needs and rely on control for self-regulation. Doubt, fear, guilt, and anxiety characterize their inner world. Attempts to individuate aren't supported, and their shame, low self-esteem, and a weak sense of self continue into adulthood – sometimes hidden behind a strong personality and/or inflated self-esteem.

Common Symptoms

The occurrence and severity of codependent traits vary and overlap to make close relationships difficult. They stem from codependents' inability to access their core self and primarily include:

- Shame
  - Perfectionism
  - Low Self-Esteem
  - Accommodation of others
  - Guilt
- Painful emotions: Fear, anxiety, depression, hopelessness, and despair
- Denial of codependency and needs and feelings
- Rigid, broken, or diffuse boundaries

- Dependency
- Dysfunctional nonassertive communication
- Control
  - Warped Sense of Responsibility
  - Caretaking
  - Feeling Superior
  - Enabling

Our Countertransference

Alice Miller believed that analysts were "narcissistically used" in childhood.

> "His sensibility, his empathy, his intense and differentiated emotional responsiveness, and his unusually powerful 'antennae' seem to predestine him as a child to be used – if not misused – by people with intense narcissistic needs . . . It is no less our fate than our talent that enables us to exercise the profession of psychoanalyst." (1981, p. 22)

Often people become psychotherapists to meet unfulfilled childhood needs, to better understand themselves, or to repeat a pattern of caretaking learned in their family. (Solomon, 1992) This caretaking role characterizes many codependents. Not working through the associated despair and rage puts therapists in danger of using their clients as they once were. (Miller, 1981) It can lead to either avoidance of issues and pain or over-identification and empathic enmeshment, accompanied by loss of boundaries, self-disclosure, over-involvement, and reciprocal dependency. (Zeigler & McEvoy)

Countertransference has been defined as the therapist's total reaction to the patient, including "the entire range of conscious, preconscious, and unconscious attitudes, beliefs, and feelings." *Subjective* countertransference reactions relate to the therapist's past and personal idiosyncrasies. They're distinguishable from *objective* countertransference reactions induced by the patient, which can provide useful therapeutic insight. (Winnicott, 1949) *Objective* countertransference may be further broken down into reactions that are *concordant,* based upon the therapist's empathic response to the client's inner, sometimes repressed, feelings, or *complementary,* based upon the client's disavowed feelings related to internal objects that are expelled and projected. (Hahn, 2000, Solomon, 1992, Racker, 1968) It's critical that therapists are attentive to their codependency so that it doesn't dictate their behavior and countertransference reactions. In fact, how "the patient's unwanted activity (is

received) may be the basis for pathological collusions or a tool for empathic understanding." (Solomon, p. 195)
Below are situations where therapists' codependent symptoms may influence their reactions to clients.

Shame

Codependents don't feel accepted for who they are. They suffer shame from not having had their affective needs met, experienced as a rejection of the self. Shame is a profound sense of inadequacy accompanied by a loss of self-cohesion and connectedness to others. (Hahn, 2000) For codependents, it isn't occasional, but is chronic, unconsciously internalized, and easily triggered. It's not always felt as such, but is often unacknowledged or camouflaged as something else. Therapists uncomfortable with their shame may defend against it by, for example, diverting the conversation, intellectualizing, losing interest, forgetting appointments, prodding clients, talking them out of self-loathing, or deciding a client isn't cooperating or can't be helped.

Shame activates both devalued and condemning internal representations. In treatment, they may stimulate the therapist's unresolved shame, resulting in concordant and complementary countertransferences. The latter includes projective identification, where the therapist can behave as the externalized object. (Hahn, 2000) Relapsing addicts, self-destructive clients, and clients who withdraw, hide their feelings, and don't communicate can induce therapists to experience a concordant countertransference identification with clients' feelings of helplessness and inadequacy, unaware that their own shame has been touched. Therapists who can't contain their shame risk unconsciously identifying with a client's externalized inner critic in a complementary countertransference and judging, reprimanding, or being overly-confrontational with the client. (Hahn, 2000) These reactions thwart use of countertransference as information to sense, contain, and explore the client's shame. Treatment stagnates as both client and therapist avoid contact with their original wounds.

Clients may compensate for shame with arrogance and/or feelings of contempt, envy, or devaluation of others, including the therapist. Shame distorts perception, so that imagined rejection can trigger humiliation and rage. The greater the aggression, the greater is the self-contempt. When therapists who haven't worked through their own shame are targeted, they might feel paralyzed or become defensive due to a complementary countertransference identification with the client's externalized devalued introject. (Hahn, 2000) A therapist would feel like the helpless, victimized child the client once was. Concordant transference occurs when through identification with clients' internal abuser

therapists join clients' criticism or attacks on others. (Hahn, 2000) Instead, what would be helpful is curiosity about the client's triggers and associations, empathy with his or her feelings, and acknowledgment of the therapist's contribution. Awareness of this dynamic allows therapists to use their countertransference reaction to relate to the clients therapeutically and help them think upon their underlying shame.

Shame and anxiety about being enough may motivate inexperienced therapists to impress new clients with interpretations that can overwhelm or break down their defenses, ensuring that they won't return. When clients leave or miss sessions, therapists may take it personally as an indication of their insufficiency or unworthiness, rather than reflecting about their misattunement or other factors.

Low Self-Esteem

Codependents' self-esteem is dependent upon others' approval. If therapists rely upon clients' appreciation and affirmation, they may indulge them to avoid disapproval. They become susceptible to manipulation, potentially forfeiting their clients' trust and opportunities to address their exploitative intent and behavior.

Therapists may accept the praise of acquiescent clients, but neither explore their shame that prevents them from crediting themselves nor their motive s for flattering and accommodating others. In such a complicit alliance, clients might not feel they can get angry at a therapist who needs to be liked, perpetuating a "false self" and mimicking a temporary cure. (Casement, 1991)

Guilt

Codependents judge themselves for their actions, needs, and feelings, and even feel guilty for those of others. Therapists may overreact with guilt about real or imaged mistakes, which prevents thoughtfulness about their meaning. Apologizing too quickly or accepting a client's forgiveness for lateness, mistakes, or lapses, such as falling asleep, or even forgotten appointments, preclude understanding the client's feelings and the reasons for the therapist's behavior. For example, sleepiness may be a reaction to projective identification of a client's disowned feeling.

Fear

Typical countertransference fears (and associated anxieties) are fear of anger, intimacy, failure, and abandonment, which includes fear of criticism and rejection.

Fear of clients' anger may stimulate a subjective countertransference based upon the therapist's prior experiences of abuse, paralyzing his or her capacity to appropriately investigate reasons for the anger, empathize with the client's unspoken pain, and possibly share his or her reaction or confront the client. An angry client might be testing the therapist's ability to set limits in order to create a sense of safety and demonstrate that the therapist can take care of herself. (Casement, 1991) In some instances, setting limits and letting clients know the impact of their behavior conveys that the therapist cares enough to be honest. Feedback to a client is useful information about how they're perceived by others. If a client blames the therapist to avoid responsibility for his or her behavior, fear or guilt might prevent a therapist from pointing out the client's pattern of abdicating responsibility for his or her behavior. (Ehrenberg, 1992)

Fear of intimacy can stimulate therapists' fear of suffocation or loss of the control that's inherent in their professional role. Because of weak boundaries and misplaced responsibility for others' feelings, therapists may feel obligated to respond in kind to clients' who express love or caring for fear of hurting or disappointing them. Fear may cause countertransference resistance in the form of detaching or rigidifying boundaries, possibly enacting an earlier emotional abandonment of the client.

Fear of rejection and abandonment can inhibit a therapeutic confrontation of acting-out behavior, lateness, late payments, verbal abuse, and issues regarding boundaries. These fears make therapists uncomfortable requiring payment for missed or late-canceled sessions – especially when clients object.

Anxiety, fear, and perfectionism can be stultifying and restrict spontaneity that allows for an authentic connection with clients. Many codependents are uncomfortable playing, yet playfulness permits a kind of intimacy and vulnerability that equalize the therapeutic relationship. Often, the best learning happens during play. In a relaxed environment, clients are free to experiment and be fully themselves, and therapists may use their imagination to translate clients' unconscious material. (1971) wrote, "If the therapist cannot play, he is not suitable for the work," wrote Winnicott. "It is in playing, and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self." (1971, p. 54)

Boundaries

Codependents' dependency needs and fears of rejection and abandonment can make maintaining boundaries a challenge, leading to boundary transgressions or

their rigid enforcement. Although there isn't consensus regarding non-sexual boundaries, it's agreed that they provide a safe, structured environment where clients can trust they won't be exploited and their destructive urges won't be allowed to destroy the therapy. However, rigid enforcement of boundaries can detract from warmth and relatedness that's therapeutic.

Typically, codependents don't attend to their own needs and defer to those of others. Therapists risk invading clients' boundaries when they depend upon them to satisfy their unmet needs – both unmet childhood needs for attention and approval as well as present business or social needs. Examples of crossing clients' boundaries are initiating hugs, inappropriate touching or self-disclosing, meeting clients socially, requesting favors, referrals, or use of clients' resources. This behavior creates a role-reversal where clients take care of their therapist, often re-enacting a parentified role that may have led to codependency and making it less likely that they'll be direct or express anger.

Therapists with damaged boundaries may experience inner conflict when clients challenge their boundaries. They may allow them to violate policies or exploit their time or resources. This is commonly an issue at the end of each session or if a client makes frequent contact between appointments. Some clients feel so exploited or deprived that every minute of the therapy session counts. Stopping on time can lead to a discussion about the client's boundaries in other relationships and associated feelings of rejection, abandonment, and even despair of ever getting their needs met.

Clients often request hugs, reminder calls, food or drink, extra time when they're late, or to use the phone, fax, or copy machine, to borrow books, or bring food, animals, or others to the session. Therapists may face the codependent dilemma of feeling resentful if they accede to the client's wishes or feeling guilty if they don't. Establishing appropriate and comfortable limits both models setting boundaries and empowers clients to do so. It teaches them that despite their childhood wish that people meet all of their needs, two adults can have conflicting needs and that both you and they can say "no" and still care about the other person.

Limits also shift to clients their responsibility of meeting their own needs. For example, a client may want extra time because he got a speeding ticket or she "couldn't" leave work on time. The issue is who should take responsibility for their behavior. Most clients wish their therapist would. This infantilizes and enables them, since the therapist suffers the consequences of their actions. By discussing the client's disappointment and ending on time, the therapist supports the adult in the client, not the child, and exemplifies boundary-setting with

others.

Denial

What we avoid in ourselves, we avoid with clients. Denial and repression of feelings perpetuate therapists' countertransference reactions and resistance to them, limiting their capacity to help clients. Countertransference resistance may take many forms, including denial, intellectualization, distraction, and detachment, in contrast to being present and engaged. When this happens, data about the client is lost. Moreover, clients sense inauthenticity in their therapist, who may lose authority and trust in their eyes, even causing them to react to the denied feelings. (Ehrenberg, 1992)

Therapists in denial about addiction in their family may not question clients about addictive behavior. They may collude with a sober spouse in denial of her partner's addiction and focus only his depression, anger, or chronic pain.

Therapists unaware of their codependency may perpetuate clients' codependency by aligning with them to change someone else. By not confronting clients' caretaking patterns and helping them build a separate self, they're enabling clients' sense of powerlessness and dependency.

Dependency

Being self-sufficient and denying needs are typical of codependents. Therapists who have disowned their dependency needs may develop a negative countertransference toward needy clients and think, "What about my needs?" These are clues to the painful past of both therapist and client. It might also signal that the therapist is neglecting boundaries or self-care. Empathic inquiry into the client's negative feelings and self-perception models compassion for the client's needy child-self.

Discussing termination often elicits clients' conflicting feelings about attachment and letting go. It may also activate a clinician's dependency needs and abandonment fears. This can make empathy with a client's position difficult. Clients may perceive their therapist to be self-serving and manipulative, driving them from treatment, especially if they felt exploited or controlled in the past. By remaining emotionally neutral, the therapist helps clients to experience their ambivalence about autonomy and dependency. Whether or not they stay, significant work can be accomplished, and if they continue, therapy may deepen as a result.

Caretaking and Control

Therapists are custodians of their clients' pain and longings – but they aren't responsible for them. This poses a problem for codependents who have a misplaced sense of responsibility and regularly assume responsibility for others' feelings and behavior. If not thoughtful, codependent therapists can harm or infantilize clients. They may feel impelled to gratify and nurture them and be reluctant to challenge, confront, or allow them to feel discomfort.

It's tempting to rescue clients, especially when a therapist's issues parallel those of the client. It's not uncommon for therapists in recovery to project their experience onto clients and not see them as unique individuals. When clients repeatedly relapse, are abused, self-destructive, or get into desperate situations, instead of helping clients think for themselves, therapists can feel compelled *to do* something. However, a therapist's role is "not a rescuer, a teacher, an ally, or a moralist." (Winnicott, 1965, p. 162). This issue is particularly true for therapists who haven't healed their own trauma and become enmeshed with the client. (Zeigler & McEvoy) They may over-identify with clients' helpless, devalued introject. Reacting to their disowned sense of helplessness, they may assume a superior, parental role induced by a concordant countertransference, inclining them to "fix" problems and advise, educate, or scold clients. (Hahn, 2000) This can create resistance and reinforce a client's self-criticism and shame, which may be contributing to the acting-out behavior.

Grief work and acceptance of our own childhood, writes Miller, is the path to wholeness and empathy as individuals and therapists:

> "Only after painfully experiencing and accepting our own truth can we be relatively free from the hope that we might still find an understanding, empathic mother – perhaps in a patient – who then would be at our disposal . . . the never ending work of mourning can help us not to lapse into this illusion . . . every mother carries with her a bit of her 'unmastered past,' which she unconsciously hands on to her child. Each mother can only react empathically to the extent that she has become free of her own childhood, and she is forced to react without empathy to the extent that by denying the vicissitudes of her early life, she wears invisible chains." (pp. 27-28)

Casement, P.J. (1991). *Learning from the Patient.* New York: The Guilford Press, pp. 145, 152

Ehrenberg, D.B. (1992). *The Intimate Edge – Extending the Reach of Psychoanalytic Interaction.* New York: W.W. Norton & Company, Inc.

Hahn, W.K. (2000). "Shame: Countertransference Identifications in Individual Psychotherapy." *Psychotherapy* 37/Spring 2000/1, 10-21

Lancer, D. (2012) *Codependency for Dummies*. Hoboken, New Jersey: John Wiley & Sons, Inc.

Miller, A. (1981) *The Drama of the Gifted Child*. New York: Basic Books, Inc.

Racker, H. (1968). *Transference and Countertransference.* Madison, CT: International Universities Press.

Solomon, M.F. (1989). *Narcissism and Intimacy – Love and Marriage in an Age of Confusion.* New York: W.W. Norton & Company, Inc., pp. 184, 197

Winnicott, D.W. (1949). "Hate in the Countertransference." *The International Journal of Psycho-Analysis, 30(2), 69-74*

Winnicott, D.W.(1965). *The Maturational Processes and the Facilitating Environment.* New York: International Universities Press.

Winnicott, D. (1971). *Playing and Reality.* New York: Basic Books, Inc.

Zeigler, M. & McEvoy, M. "Hazardous Terrain: Countertransference Reactions in Trauma Groups." http://www.psybc.com/pdfs/Hazardous.pdf.