

MY "CONSCIOUS" COUNTERTRANSFERENCE

Countertransference is a frequent experience in geriatric setting where aged clients represent grandparents and parents. It is not to be assumed that the effect of countertransference is always negative. In fact, it may lead to mutual benefits for the client and the worker. This narrative describes how my own countertransference enabled me to help an elderly client negotiate personal conflicts and alleviate my feeling of loss, grief and guilt.

By Agathi Glezakos

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"To help is to enter the existence that is the other's." (J.H. Van Den Berg, 1955)

The first forty days of my orphanhood had come to an end. During their course I learned that to lose a mother is a terrible thing.

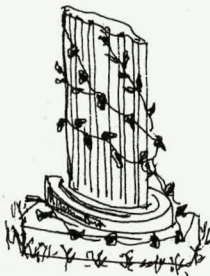
My mother died three days before my arrival to her small town in Northern Greece from my distant residence in the United States. I was not by her bed-side during her final hours. I had missed her funeral and was stricken with grief as I knelt next to her freshly dug grave. During the ride to the cemetery from the airport, family members described how fiercely my mother fought to stay alive to hold on just until I arrived. My mother was not ready to die until she could give me her final blessing in the way she had done with them. Struggling to hold on to life "she had suffered greatly" they said; even "needlessly," one of them added. Grief and guilt engulfed me. Forty days after her death, the intensity of these emotions had not subsided.

For forty days I had mourned her loss as the Greek culture prescribes, with daily religious rituals, rites, and leave from work. The mourning

period had now come to an end and I was returning to work in a skilled nursing facility where I provided consultative services. I was apprehensive about returning to a setting surrounded by disabled elderly clients with death a frequent occurrence. On and off, I caught myself dissecting and analyzing my emotions. I needed assurance that I could operate in an environment that would put to test my objectivity and professionalism.

I had consulted with skilled nursing facilities for twelve years and knew that their social workers showed high levels of empathy and emotional intensity in their client relationships. I had explained to the staff the meaning of countertransference and the need to monitor the possibilities of countertherapeutic effects. Now, I was concerned about the effects of my own countertransference!

My first day back was productive and rather emotion free. The work day had come to an end and I was about to leave for home. I said good-bye to the social worker and finished my regular exit interview with the facility's administrator. As I neared the end of the hall-way



my thoughts shifted to grocery shopping for my family's dinner.

It was not the bustle at the main entrance made by the ambulance attendants and the staff that brought me to a stop and pulled me back inside. This was a scene I witnessed many times. My usual response was to rush quickly through the commotion, away from others' responsibility. With an overstuffed briefcase over my shoulder I leaned against the wall and felt my body tensing up, immobilized. My emotions were racing.

In front of me, on the gurney that the ambulance attendants were trying to push through the door laid the skeleton like, shrunken body of an elderly woman wrapped in a white hospital sheet. She grasped one end of the door and refused to let go. Ferocious in the way she held the door her faint but clear voice overpowered all others. "Only over my dead body will you take me in there. I have a home and I wish to die in my own home. I am not going to die in this dump of a hospital, among strangers." The old woman's resistance lasted several minutes. There was no force on anyone's part to oppose her, though it was obvious the staff were anxious to finish admitting her.

I motioned to the nurse supervisor to allow me to intervene. My social work skills with "problem" clients had been tested more than once in this supervisor's presence. She nodded in agreement. I freed my aching shoulder from the weight of the briefcase and approached

the gurney. The frailty of the old body was more severe than I had expected. The body parts exposed—her face, her neck and shoulders, her hands and fingers — were nothing more than "skin and bones." Her heavily wrinkled face surrounded by long white hair was wet from perspiration, the product of her resistive effort.

Her name was Contesa Alfano and she was eighty-nine years old. I introduced myself and talked to her in the calmest, most assuring tone of voice I could muster. I knew how critical this intervention was in reducing her resistance and fear. "Mrs. Alfano, you have been brought to a strange place without your permission and you are angry about that. You wanted to be taken to your own house instead, where you have probably lived for many years. I understand why you do not want to come to an unfamiliar place when you do not feel well, and to be among people whom you do not know. Many people feel the way you do when they first come here. While I do not yet know the specifics of your health condition and your health care needs, I want to assure you that your doctor chose this hospital because he felt you are not yet ready to return to your own home and that you need the different types of therapies and the nursing care you will receive here. Before you go in, I would like to introduce you to some of the people who you will see here daily so that you may start feeling that you are among friends. Would you be interested

in meeting them?"

By this time I had placed my hand on her arm, wiped the perspiration from her face and arranged her hair pulling it back and tying it into a knot. I then straightened the hospital gown to cover her bare shoulders and the twisted sheet to give her some comfort. Old and helpless, stripped of the power to make decisions, she still needed to be treated with respect and dignity. Her body's rigidity appeared to settle into a more relaxed state. The change in her facial expression was encouraging.

I turned to one of the nurse aides and asked her to summon the social worker and the therapists from the rehabilitation program. I introduced the nurse supervisor to Mrs. Alfano. Soon, other staff members arrived and, one by one introduced themselves acknowledging the legitimacy of her behavior and their interest in her well-being. Standing to the side, I observed her hand's gradual release of the door. Glancing at the many faces around her, Mrs. Alfano rested her right arm on the gurney and held on to me with her left hand. She did not utter a word, but her demeanor sent the message she was ready to let the team wheel her into her new "home."

The hallway was empty again as I picked up my briefcase. I was running late and had other things to do. As I drove away from the hospital I found myself engulfed in a myriad of emotions. Concerned about this new chapter in Mrs. Alfano's life, I felt an increasing desire to make sure that it would be

characterized by the principle of integrity and self-validation, trust that others would attend to her needs when she could no longer do so, reception of help without diminished self-worth and acceptance of the possibility of death away from her own home.

These were all wishes that my own mother expressed to me the previous summer when I had returned to my parental household for a brief visit. Earlier that year both my parents suffered cerebrovascular accidents which left them with moderate speech and physical impairment. In the course of our conversations I found they were unexpectedly open with their thoughts and feelings about their own and about each other's death.

Of the two, my mother seemed the least ready to negotiate the possibility that before to long her life might come to an end. After all, she was ten years younger than my father and at the age of seventy-eight she still had dreams to fulfill. My mother was despairing. She was not ready to die, yet, having lost so much of her functional ability she was sharply aware of her mortality.

I have often revisited that last morning together. She had hugged me, looked at me in an unusually penetrating way and said: "I might not live long enough to see you again and I want you to know that I love you." I was not yet ready to lose her and missed the chance to comfort her, saying instead: "Of course we will see each other

again; I promised to be back next summer, you remember?"

With each subsequent review of our discussion that summer, my insight into my mother's thoughts and feelings was heightened. In her own ambivalent way, she prepared for her death. She chose the clothes that she wished to be dressed in, the type of casket she wanted to rest in, the food to be served after her funeral; even the serving pieces to be used. As she instructed all of us in what to do, she said that her deepest fear was that her health might deteriorate to a point where she would require hospitalization and die on a hospital bed.

Each recollection sharpened my pain. Despite her expressed wishes and valiant effort, my mother died in the hospital, away from the home she helped build and had come to cherish. Days before her death, a massive stroke transformed her from a moderately ambulatory woman to a semi-comatose patient. Her doctor had made the decision to admit her to the hospital, and my father consented. "This is an emergency" he told me over the phone when I asked if this would have been her choice. "As soon as her condition stabilizes we will bring her home." With this plan in mind, he prepared her "recovery" bed next to the large front window so she could watch the village life below. Days after admission to the hospital, my mother succumbed to a stroke. Now the terror on Mrs. Alfano's face as the attendants tried to wheel her

into the skilled nursing facility became, in my mind, the terror my mother felt as the ambulance transferred her from her house to the acute hospital.

"Violating" my mother's wish to die at home was an unsettling event for the family. In the days that followed, each one of us in our own way tried to resolve the internal conflict that had surfaced. Transcending my feelings of anger, sadness, guilt and unique personal pain, the question: "Would my physical presence there have made a difference?" seemed to always face me!

In the month following admission, Mrs. Alfano earned the label of "a problem resident." She was non-compliant with the prescribed health care regiment and used abusive language with her peers and staff. The psychotropic medications prescribed for her behavior management were ineffective. Plans were now being made to transfer Mrs. Alfano to an in-patient geropsychiatric unit. Although the effectiveness of geropsychiatric units in modifying patient behavior during hospitalization, (the duration often decided by insurance companies) had not been proven. Transplanting residents from a skilled nursing facility to these units added new trauma to their lives already bruised and wounded by multiple losses. Hearing of the plans to transfer Mrs. Alfano, I rejected the idea.

I talked with several members of the interdisciplinary team to understand the nature of

Mrs. Alfano's behavior and assess the appropriateness of staff interventions. Did they comprehend the underlying dynamics of the problem behaviors? Did they respond to her needs promptly and empathetically? How could we make Mrs. Alfano a more "appropriate" resident for this facility so as not to subject her to another relocation, one with the potential to cause more trauma? These were the questions I asked, and as I did so, I was aware of my keener than usual interest in this client.

During an interview I conducted with Mrs. Alfano later in the day, the emotional quality of our interaction ranged from her refusal to talk with me, offensive and abusive language, verbalizations of despair and fear and, ultimately, to ask for my help.

As the interview unfolded, I recognized the fear and despair my mother had expressed the summer before in Mrs. Alfano's words. Not strong enough to respond to my mother's feelings nor ready to consider orphanhood, I missed the opportunity to listen to my mother, I now wanted to help Mrs. Alfano. Her silence and offensive language became my challenge. I wished to meet the challenge for her benefit and my own.

Lying on the bed in a semi-private room she shared with a disoriented roommate, Mrs. Alphonso appeared as a frightened elderly woman unwilling to acknowledge her limitations, or to make the necessary transitions and

adaptations. She asked to return to her own home when she had no ambulatory capacity to move about. She needed daily physical and occupational therapy and twenty-four hour skilled nursing care. She had no informal support system. She was non-compliant with her prescriptions because she had read that medications adversely affect a person's body and mind, and she was not ready to allow a chemical substance to compromise the control she had over her own destiny. She feared her roommate would take her personal possessions or stand over her bed in the middle of the night. She used abusive language with the staff because they were always in a hurry, never taking time to talk to her. This situation, she said, forced her to become someone different from the independent person she had been prior to fracturing her hip when she fell from a ladder as a result of a cerebrovascular incident.

As the interview progressed, Mrs. Alfano felt more comfortable and brought me into her world before the accident. As I directed her into a brief life review I learned that when she was seven years old, she and an older sister were placed in a orphanage after their parents' death. Two years later, not willing to accept life in an oppressive environment, she escaped, hiding among tall milk cartons in a covered wagon. This escape was followed by a series of indentures with several families and encounters with local authorities until her first

marriage at the age of sixteen. In all, she married three "good for nothing husbands." She always worked, supported herself and saved enough to buy the house in which she lived until the day of her fall. She remained childless and always her "own boss." As she brought her life's account to a conclusion, I had a better insight into the dynamics of her present behavior and I became more committed to help her.

I planned four immediate objectives to address before the end of the day: (1) discuss Mrs. Alfano's prognosis and assess her potential for home discharge with the interdisciplinary team; (2) make arrangements to match Mrs. Alfano with a more alert, oriented and articulate roommate; (3) conduct a brief staff in-service training on the psycho-emotional needs of the client and offer instructions on health care approaches to improve client-staff relations; and (4) receive administrative approval to visit Mrs. Alfano once a week for the next three weeks.

Later in the day I met with the interdisciplinary team to develop new care plans, and assess Mrs. Alfano's health care needs, level of functioning for activities of daily living, and the psychological benefits of discharge to her own home with home health care assistance. Discharge was unanimously ruled out; Mrs. Alfano's physical needs were great and the lack of an informal support system would jeopardize her well-being if placed under the care of paid

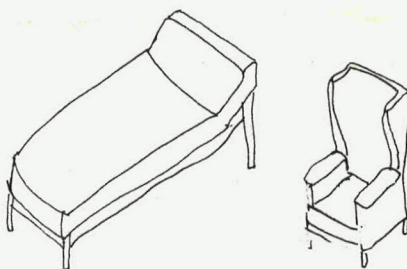
help. In addition, her behavior and past and present relational skills signaled potential conflicts with a paid health care aide. The team concluded she needed to remain in the facility until her physical condition improved and she regained the capacity for assisted living in her own home or at a lower level of care setting. The team concurred with my recommendation to match Mrs. Alfano with a roommate whose level of functioning was at a comparable level to hers (thus increasing her opportunity for conversation and alleviating distress.) The facility's administrator and Mrs. Alfano's attending physician eagerly accepted my proposition for three consecutive weekly sessions.

During the course of the day, my interventions helped me to get to know Mrs. Alfano better and develop care plans relevant to her individual needs. While my involvement with this case did not differ from my usual interventions with clients, the emotional intensity with which I intervened made me question my professionalism. I was also aware of recurring images during my work with Mrs. Alfano; images carrying me back and forth from the client's reality to my mother's last phase of life and death in a hospital.

On the way home that afternoon, I was preoccupied with the day's events. The intensity of involvement with Mrs. Alfano reflected my interest in assisting not just a client, but someone who had become "special" "Am I allowed to have

a special client?" I asked myself. Realizing that I was engaging in countertransference, I needed to safeguard my future interventions for possible countertherapeutic effects.

Countertransference is a topic that I discuss with my graduate social work classes. I am familiar with its definition. Nevertheless, I reviewed sources previously used for class preparation. In the social work literature (Woods and Hollis 1990) I read that "countertransference reactions are unavoidable occurrences in the life of the caseworker...a number of preventive measures... can be cut down on the quantity and intensity of countertherapeutic responses..." (pp. 422-23) In the psychiatric literature countertransference was viewed as the phenomenon that "also included those situations where the patient serves merely as a tool to gratify some need of the analyst, such as alleviation of anxiety or mastery of guilt feelings." (Campbell 1989, 162)



Wishing to prevent countertherapeutic snares in future contacts, I sought peer consultation from colleagues. With their assistance and careful self-analysis of my practice, I was able to differentiate

between realistic and unrealistic objectives in my work with this client. I then wrote the following list: Realistic/objective responses: (1) Facilitate Mrs. Alfano's adjustment to the facility milieu; and prescribed health care regimen. (2) Work with staff to increase their understanding of Mrs. Alfano's individual needs and the underlying dynamics for her behaviors; jointly develop and implement realistic behavior modification plans. (3) Alleviate Mrs. Alfano's present feelings of helplessness and diffuse her anger. (4) Ascertain Mrs. Alfano's readiness to engage in exploration of death and dying issues. (5) Assist in the development of sound discharge plans at the appropriate time. Unrealistic/subjective responses: (1) Assume responsibility for Mrs. Alfano's despair. (2) Search for the "magic wand" that would help return her to her pre-accident way of life and functioning. (3) Blame the facility's staff for Mrs. Alfano's difficulties in her adjustment.

When I returned to the facility the following week, I explained to Mrs. Alfano the special arrangement that had been made for our three consecutive weekly meetings and shared with her the list of my "realistic" objectives. I invited her input. She agreed with the objectives and to abide by all rules and expectations so that she could return to die in her own home. This open exchange arrested the ambivalence I felt about my ability to practice objectively.

Our subsequent meetings lasted thirty to forty-five

minutes, the range of Mrs. Alfano's attention span. Progressively, the periods of silence became shorter. Cautiously, but with a clearer sense of trust, she shifted from complaints about the quality of her care and the confused and "loonie" old people surrounding her, to recalling personal experiences, historical facts, her feelings and emotions about her death, and fears about the unknown future.

The weekly sessions yielded encouraging results. Mrs. Alfano carefully circled the date of my next visit on her calendar, and talked about the progress she was making, the new friendships she was enjoying and the possibility that it might be some time before she would be ready to return to independent living. Staff reports presented her as a "compliant, pleasant, female resident." Although she expressed disappointment when the time came for us to switch our schedule from weekly to monthly visits, she understood and accepted the decision.

In the September session Mrs. Alfano reminisced about personal holiday traditions, celebrations, favorite recipes and special menus. She talked of her annual visit the day before Thanksgiving to Marie Callender's restaurant to buy a pumpkin pie. "Theirs is the best, you know" she said. "I could not afford to have it more often than just once a year. But one pumpkin pie would last for several days and I enjoyed every sliver of it." The following month, just before Thanksgiving, I returned

to the hospital with a Marie Callender's pumpkin pie.

Soon after my arrival, the social worker informed me that Mrs. Alfano had pneumonia and had taken a downward turn. She had not gotten out of bed for several days. I visited her in the early afternoon with coffee and pie. The gesture moved her, and she profusely expressed appreciation as she ate a small piece of the pie with noticeable effort. In between small bites she found strength to say: "This will be my first Thanksgiving away from my home. I wish I were dead. I wish I will die before Christmas. I do not want to spend my holidays away from home. You know, I have this feeling that I will die before Christmas... I know I will die before Christmas... I might not see you again." This time, I did not rush to discount what I heard. I listened in silence. She knew it was acceptable to express these thoughts and feelings. She knew what I did not know, maybe even what her physician and the nurses did not know. **She was linked to her own dying process.** When she stopped I dared to ask: "What does it feel like to know that your life is coming to an end? What does it feel like to acknowledge your "non being?" She answered that in the past two months she had come to accept her mortality, the inevitability of her death. At that moment, I was aware of my need to know the feelings of one approaching death, so I might better understand my mother's emotional state towards the end of her life. However, I believe

this exchange between the dying client and the helping professional has therapeutic effects for the client.

Ten days before Christmas I found Mrs. Alfano suffering from severe pneumonia.

Recognizing me, she took hold of my hands and in a barely audible voice said: "Thank you for being here. Thank you for all the visits and your help. You made a difference. My time here was not that bad after all. I will not make it to our next meeting. **I will die before Christmas.**" Moving closer to her, I focused on the yellowish, already lifeless eyes and put my arms around her. It was my turn to express appreciation for the privilege of knowing her, for all she had taught me about the process of adjustment and adaptation, of dying and death, and of the place of countertransference in social work practice with a frail elderly client. I pulled myself away from Mrs. Alfano and stood in awe, looking at the body, the face, the person I might not see again, now more than ever, aware of my mother's physical absence from my life.

On December twenty-second, I received a phone call from the facility's social worker informing me of Mrs. Alfano's death that morning. "She died peacefully. All of her wishes as she expressed them on the Advance Directives form were respected. No cardiopulmonary resuscitation, no antibiotics, no transfer to the acute hospital. Her friend was with her at the time of her death. I knew you would want to know," she said.

I hung up the phone and stared at the wall in front of me for several minutes recalling how William Schwartz (1971) had viewed the social worker as an incident in the lives of clients. "The life processes into which the worker enters and makes his limited impact have been going on for a long time before he arrived." (p. 13). Thoroughly aware that I was one incident in this client's life experiences, I knew that in the final phase of her existence I had made a difference.

Mrs. Alfano died before Christmas, just as she had hoped. Four months earlier my own mother had died when she, as others told me, was not ready to die. I knew that Mrs. Alfano, through a combination of acceptance and resignation succumbed to death with a sense of integrity. I wondered whether my mother, with still unmet wishes, fighting to stay alive and without enough power to do so might, indeed, had died in despair!

Both of these women died. We all die. I, too, will die. I slowly rested my head on top of the desk, and in my privacy I cried. □

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