WORKING WITH TRAUMATIZED TEENS

HOW TO GET UNHOOKED

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WEEK THREE

PLAN FOR SESSION THREE

THE THERAPIST'S ATTACHMENT STYLE

- **THERAPY AS A SPECIFIC ATTACHMENT RELATIONSHIP**
- **ATTACHMENT THEORY IS REGULATION THEORY**
- **DOES THE THERAPIST NEED TO BE SECURE?**
- **ATTACHMENT STYLES AND COUNTERTRANSFERENCE**
- **SELF DISCLOSURE AND ENACTMENTS**
- **LAUGHING AND CRYING IN THERAPY WITH TEENS**

YOUR TASK IS NOT TO SEEK FOR LOVE, BUT MERELY TO SEEK AND FIND ALL THE BARRIERS WITHIN YOURSELF THAT YOU HAVE BUILT AGAINST IT.

-RUMI

DOES THE THERAPIST NEED TO BE SECURE?

- **Ideally, yes (or at least earned-secure). OR at least reflective and mindful about less secure styles**
- **Secure models of attachment result in an open, flexible, and non-defensive approach to attachment related issues.**
- **This in turn translates into approaches to others that are open, receptive and collaborative. These characteristics are likely to facilitate a positive therapeutic alliance.**

THERAPIST INSECURITY

- **Studies report poorer therapeutic alliance with therapists assessed as insecure.**
- **Insecure therapists tend to intervene in such a way that fails to challenge the client's customary affect regulation strategy.**
- **Insecure therapists report more problems in their therapy with clients.**

THERAPIST INSECURITY…

Anxious (preoccupied) therapists:

- **Interpret ruptures in therapy as negative**
- **Tend to be less empathic because of their own anxiety about loss.**
- **Could also become activated by preoccupied clients.**

THERAPIST INSECURITY…

Dismissing therapists:

Are likely to be overwhelmed by emotional reactivity of preoccupied clients.

Can miss the important emotional and relational issues of dismissing clients.

Complimentary (activating with deactivating, and vice versa) can be better than similar styles.

From *A General Theory of Love*

"THE PERSON OF THE THERAPIST WILL DETERMINE THE SHAPE OF THE NEW WORLD A PATIENT IS BOUND FOR; THE CONFIGURATION OF *HIS* LIMBIC ATTRACTORS FIXES THOSE OF THE OTHER. THUS THE URGENT NECESSITY TO GET HIS EMOTIONAL HOUSE IN ORDER. HIS PATIENTS ARE COMING TO STAY, AND THEY MAY HAVE TO LIVE THERE FOR THE REST OF THEIR LIVES."

(Lewis, Amini, & Lannon p. 187)

ADULT ATTACHMENT INTERVIEW (AAI)

The Adult Attachment Interview asks the subject about his/her experiences with parents and other attachment figures, significant losses and trauma and if relevant, experiences with their own children.

The interview takes approximately 60-90 minutes. It is then transcribed and scored by a trained person (two weeks of intensive training followed by 18 months of reliability testing).

The scoring process is quite complicated, but generally it involves assessing the coherence of the subject's narrative.

GRICE'S MAXIMS OF DISCOURSE

One aspect to scoring the interview is looking for examples of and violations of Grice' s Maxims of Discourse. These maxims are:

Quality: Be truthful and believable, without contradictions or illogical conclusions.

Quantity: Enough, but not too much information is given to understand the narrative.

Relevance: Answers the questions asked.

Manner: Use fresh, clear language, rather than jargon, canned speech or nonsense words.

In addition to coherence, there are specific scales related to secure and insecure categories.

ADULT ATTACHMENT INTERVIEW & SCORING

SECURE/AUTONOMOUS – Coherent Narrative

- **Value attachment relationships, recognize influence**
- **Descriptions are full, balanced, affectively congruent**
- **Discourse is internally consistent, non-defensive**
- **Narrative is linear, logical, complete**
- **All four Grice's Maxims met: Quality, Quantity, Manner, Relevance of responses**

AAI SCORING

Dismissing: Not coherent.

Minimizing of attachment-related experiences and relationships.

Normalizing ("excellent, very normal mother"), with generalized representations of history unsupported or actively contradicted by episodes recounted, thus violating Grice' s maxim of quality.

Transcripts also tend to be excessively brief, violating the maxim of quantity.

AAI SCORING

Preoccupied: Not coherent.

Preoccupied with or by past attachment relationships or experiences, speaker appears angry, passive or fearful.

Sentences often long, grammatically entangled or filled with vague usages where something is left unsaid (e.g., "dadadada"; "or whatever") thus violating Grice's maxims of manner and relevance.

Transcripts are often excessively long, violating the maxim of quantity.

AAI SCORING

Unresolved/Disorganized: Not coherent.

During discussions of loss or abuse, individual shows striking lapses in monitoring of reasoning or discourse.

Individual may briefly indicate a belief that a dead person is still alive in the physical sense, or that this person was killed by a childhood thought.

Individual may lapse into prolonged silence or eulogistic speech.

WHAT IS YOUR ATTACHMENT STYLE?

TIME FOR SOME PERSONAL WORK

NOT THE AAI BUT HERE ARE SOME SIMILAR QUESTIONS TO THINK ABOUT AND SCORE YOURSELF

REMEMBRANCE

-What was it like growing up?

-What kind of people did you have in your family?

-What was your parents' philosophy of raising kids?

-What did you like about your childhood? What didn't you like?

-How are you raising/planning to raise your children—same or different?

RELATIONSHIP

- -Did you get along well with your parents?
- -How has your relationship changed over time?
- -How did your relationship with your mother differ from the one with your father?
- -How were they similar?
- -Describe three characteristics of your childhood relationship with each of your parents? Why did you choose these adjectives
- -Are there ways you try to be like, or not like, each of your parents?

SEPARATION

- -Do you recall your earliest separation from your parents? How did it feel?
- -Was there ever a prolonged separation from your parents?
- -If you are a parent: Have you ever been separated from your child?

TRAUMA

- -Did you ever feel rejected or threatened by your parents?
- -Were there other overwhelming or traumatizing experiences in your life? During your childhood? Since then?
- -Do any of the these experiences still feel very much alive?
- -Do they continue to influence your life?

LOSS

- -Did anyone significant in your life die during your childhood? Later in life?
- -What was that like for you at the time?
- -How does that loss affect you now?

BONDS

-How did your parents communicate with you when you were happy or excited?

-Did they join you in your enthusiasm?

-What happened when you were distressed or unhappy as a child?

-Did your father and mother respond differently? How?

COMMUNITY

-Did anyone else besides your parents take care of you during your childhood?

-What were those relationships like? What happened to those people?

-If you are a parent: What is it like for you when others take care of your kids?

REFUGE

-Were there positive relationships inside, or outside, your home that you could depend on during difficult times during your childhood?

-How do you feel those connections benefitted you then?

-How might they help you now?

IMPRESSIONS

-How have your childhood experiences influenced your relationships with others as an adult?

-How has your own childhood shaped the way you relate to your children and your clients?

THE RELATIONSHIP QUESTIONNAIRE (RQ) (HANDOUT)

Bartholomew, K. & Horowitz, L. M. (1991).

____ A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.

____ B. I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.

____ C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

____ D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

KNOW YOUR ATTACHMENT STYLE

IF YOU ARE ANXIOUS OR AVOIDANT WILL HAVE TO BE EVEN MORE AWARE OF COUNTERTRANSFERENTIAL PULL

WARM-COOL (COLD NEVER WORKS)

CLOSE-DISTANT

ACTIVE-PASSIVE

TOLERANT OF AMBIGUITY-REQUIRING CLARITY

AVAILABLE-STRUCTURED

COUNTERTRANSFERENCE AND ATTACHMENT STYLES

COUNTERTRANSFERENCE IS ALWAYS PRESENT, SO EXPECT IT!!!

Consider it a valuable source of information

Think about how your own models of love interact with what gets activated for you when working with a teen

- Seek to talk about it with colleagues and supervisors
- Seek to explore and understand it
- When caught in enactments, try to use them to understand the the teen. Maintain therapeutic boundaries!!! Be aware of personal limitations and vulnerabilities. Seek consultation as needed.

Factors That Interact to Determine Countertransference

- The nature of stressor in the event and recounting
- Personal factors in the therapist
- Patient factors relevant to understanding countertransference
- Institutional/organizational/societal factors—we and our clients are both affected by the contexts of our helping
- Ex: overwhelmed student in primary care without an office working with homeless kids.

COUNTERTRANSFERENCE INDICATORS

- Physiological and physical reactions
- Emotional reactions
- Psychological reactions
- Signs and symptoms that may be conscious or unconscious:
  - forgetting, attention lapses
  - loss of empathy
  - anger, hostility
  - relief when appointment is missed
  - denial of feelings or need for consultation
  - excessive concern
  - psychic numbing
  - self-medication
  - loss of boundaries (Wilson & Lindy, 1994)

COUNTERTRANSFERENCE REACTIONS IN TRAUMA TREATMENT

- Fascination, overinvolvement
- Underinvolvement
- Horror, disgust, fear
- Shame, guilt
- Anger, rage, irritation
- Sadness, sorrow, grief
- Powerlessness, overwhelmed, exhausted
- Incompetence, de-skilled, confusion
- Sexualization, voyeurism, exploitation, sadomasochism
- Difficulty with boundaries and limits

SELF DISCLOSURE & ENACTMENTS

IMPASSES, RUPTURES, BAFFLEMENT, AND USING UNFLINCHING EMPATHY TO GET UNHOOKED

Psychotherapy is a "shared journey of inescapable mutual influence"

(Schultz-Ross, Goldman, & Gutheil, 1992)

WHEN AND HOW TO SELF DISCLOSE

- TEEN CLIENTS NEED TO HAVE US BE "REAL PEOPLE"—BUT NOT TOO REAL: BEST SELVES
  - MAKE DECISIONS ABOUT SELF DISCLOSURE ALWAYS KEEPING IN MIND THAT IT HAS TO HELP THEM, NOT YOU.
  - ASK YOURSELF HOW THE SELF DISCLOSURE WILL BE HELPFUL TO THE TREATMENT—AND HOW IT MIGHT BE HARMFUL IF THEY HAVE TO BE THINKING ABOUT YOU.
  - SELF DISCLOSURE ABOUT HOW YOU ARE THIINKING AND FEELING ABOUT THEM CAN MAKE YOU A REAL ADULT WITHOUT MAKING IT ABOUT YOU
    - I'M WORRIED ABOUT TELLING YOU WHAT TO DO" "I'M SO HAPPY THAT THIS WORKED OUT FOR YOU" "I'D BE REALLY CONFUSED IF THAT HAPPENED TO ME, TOO"
  - SELF DISCLOSURE ABOUT SHARED INTERESTS (TV, MUSIC, VIDEO GAMES) CAN BE FINE

QUESTIONS TO ASK YOURSELF

- How will my client benefit from knowing this information?
- Is there a way that I can validate and empathize with my client without self-disclosing information?
- What are the reasons behind my feeling to self-disclose?
- Am I being triggered by these discussions with teens during sessions in an attempt to be mindful of using self-skills while in session?
- What would my supervisor say or think about this situation?
- Do I have unresolved emotional issues that are causing me to want to share this information?
- Am I nervous if I don't share this information or answer the teen's question that she will be upset with me?
- How will my client interpret my self-disclosure?

FOUR TYPES OF SELF DISCLOSURE

1) DELIBERATE:

- **self-revealing:** disclosure of information by therapists about themselves.
- **self-involving:** therapists' personal reactions to clients and to occurrences that take place during sessions

- SELF-INVOLVING IS ALWAYS SAFER AND OFTEN VERY USEFUL. SELF REVEALING CAN HARM ESSENTIAL BOUNDARIES (HAVE A CARETAKING TEEN WORRY ABOUT YOU, HAVE A TEEN NEEDING TO FEEL SPECIAL EXPERIENCE HERSELF AS LESS IMPORTANT)
- THEY NEED YOU TO BE AN ADULT IN THEIR LIVES. YOUR ADOLESCENCE SHOULD BE IN THE PAST.

FOUR TYPES OF SELF DISCLOSURE

2) **UNAVOIDABLE:** therapist's gender, age, place of practice, tone of voice, pregnancy, foreign or any accent, stuttering, visible tattoos, obesity and many forms of disability, such as paralysis, blindness, deafness or an apparent limp. manner of dress, hairstyle, use of make-up, jewelry, perfume or aftershave, facial hair, wedding or engagement rings, or the wearing of a cross, star of David or any other symbol (Zur, 2007).

- WE UNAVOIDABLY REVEAL A LOT ABOUT OURSELVES: THESE KIDS ARE EXPERT DETECTIVES SO WE MAY BE DISCLOSING JUST BY SHOWING UP AS OURSELVES

- SOMETIMES THEY WILL ASK A DISARMING QUESTION AND BEFORE WE KNOW IT, WE'VE ANSWERED. MIGHT NOT BE A BIG DEAL BUT IT CAN BE A STRATEGY TO GET THE HEAT OFF OF THEM AND APPEAL TO OUR VANITY—WHICH CAN RUPTURE THE THERAPY IN A MINUTE.

FOUR TYPES OF SELF DISCLOSURE

3) ACCIDENTAL: incidental (unplanned) encounters outside the office, spontaneous verbal or non-verbal reactions, or other planned and unplanned occurrences that happen to reveal therapists' personal information to their clients

- INCLUDES EMOTIONAL RESPONSE LIKE LAUGHING AND CRYING AS WE'LL DISCUSS IN A BIT
- IN A SMALL TOWN (AS I LIVE IN), I SEE PATIENTS EVERYWHERE; OVER THE YEARS, SOME HAVE KNOWN MY CHILDREN
- ACCIDENTAL SELF DISCLOSURE NEEDS TO BE DISCUSSED. "WHAT WAS THAT LIKE FOR YOU TO SEE ME AT THE MOVIES?" "I GOT PRETTY WORKED UP THERE. HOW WAS THAT FOR YOU?"

4) **GOOGLE AND OTHER WEB RESEARCH PROJECTS:** DON'T BE SURPRISED IF THEY KNOW MORE ABOUT YOU THAN YOU MIGHT LIKE TO KNOW…

HELP!!!!! WHAT IS GOING ON HERE??

SELF-INVOLVING DISCLOSURES AND ENACTMENTS TO GET USTUCK

MIRRORING: RH TO THE RESCUE WITH EMPATHY

- **PERCEIVE THE EMOTIONAL STATE OF THE OTHER—THEIR PAIN OR JOY IN YOUR HEART AND MIND**
- **OUR MIRROR NEURONS SIMULATE THE MENTAL STATE OF THE CLIENT (DATA YOU ARE COLLECTING ANYWAY, AUTOMATICALLY)**
- **OUR BODY CHANGES IN RESPONSE TO THE EMOTIONAL STATE (GETTING HOOKED)—THEY HAVE TO GET TO YOU—AND BOTH OF YOU HAVE TO KNOW IT!!!**
- **WE FEEL THE EMOTION—CORE OF EMPATHIC ATTUNEMENT**
- **WE LABEL THAT CHANGE (ANGER, SADNESS, FEAR, CONFUSION, TERROR, SURPRISE, DISGUST, JOY, EXCITEMENT)**
- **IS THIS ME OR IS THIS YOU I AM FEELING NOW? [BONUS CHALLENGE!!!!]**
- **EMOTIONAL EMPATHY INVOLVES LEARNING TO CONNECT WITH YOUR OWN EMOTIONS FIRST!!! AFFECT HEALS AFFECT**

WHAT IS ENACTMENT?

CLIENT IWM/DYNAMICS ARE REPLICATED, PLAYED OUT IN THE THERAPY RELATIONSHIP

CAN HAPPEN IN SPITE OF OUR BEST EFFORTS, OR IN THE MIDST OF AN INTERVENTION

IF WE DON'T FACE ENACTMENTS, THE ALLIANCE WILL CRUMBLE, IMPASSE, DROPOUT

PARADOX: THE HEALING OF THE WOUNDS IS INSEPARABLE FROM THE ENACTMENT OF THE WOUNDS

YOUR GETTING HOOKED/ENTANGLED CAN LIGHT THE WAY OUT IF YOU REALIZE, FEEL, AND DEAL WITH IT

INVOLVE YOURSELF AND YOUR FEELINGS ABOUT WHAT IS HAPPENING IN REAL TIME TO PROVIDE CORRECTIVE RELATIONAL EXPERIENCES

SELF DISCLOSURE TO GET OUT OF ENACTMENTS

DESCRIBE YOUR ROLE IN THE ENACTMENT:

" I WAS TRYING SO HARD TO SHOW YOU HOW GREAT THERAPY WAS GOING TO BE, I DIDN'T GIVE YOU ENOUGH ROOM TO BE PISSED OFF ABOUT HAVING TO COME HERE"

"I THINK I MIGHT BE SOUNDING A LITTLE LIKE YOUR MOTHER TODAY, GIVING TOO MUCH ADVICE AND NOT REALLY HEARING YOU"

"I HAVE AN IDEA, BUT I HEAR YOU WHEN YOU TELL ME YOU'VE TRIED EVERYTHING ALREADY. I'M WORRIED YOU'LL SHOOT IT DOWN BEFORE I BEGIN."

SELF DISCLOSURE TO GET INTO ENACTMENTS

LOTS OF INFO IN SESSION, NOT MUCH AFFECT

CLIENTS (ESP DISMISSIVE) RELY ON REPORTING FACTS, NOT MUCH LIVED EXPERIENCE.

CAN FEEL A LITTLE DULL AND DISCONNECTED

"I'M HAVING TROUBLE GETTING AT THE HEART OF THIS. CAN WE TALK JUST ABOUT WHAT YOU FELT AFTER YOU HUNG UP THE PHONE WITH HER?"

"WHOA, I'M TOTALLY LOST. DID YOU FEEL ME DRIFT OFF A LITTLE? WHAT WAS THAT LIKE?"

SELF DISCLOSURE TO INCREASE CONNECTION

SLOW DOWN A CONVERSATION TO MAKE ROOM FOR BOTH AFFECT AND AWARENESS TO COME IN

NOTICE, DESCRIBE, ENACT, NAME EXPERIENCES, ASK TO SIT A MINUTE AND SEE WHAT COMES UP BECAUSE YOU NEED TO SLOW IT DOWN

"I FELT A LITTLE SAD WHEN YOU WERE TELLING ME THAT STORY EVEN THOUGH YOU WERE SMILING"

"YOU LOOKED A LITTE WORRIED WHEN YOU SAID THAT. I'M A LITTLE WORRIED, TOO. BUT WE'LL FIGURE IT OUT TOGETHER"

"I THINK IF THIS HAPPENED TO ME, I MIGHT BE MORE FREAKED OUT."

SELF DISCLOSURE TO PUT DIFFICULT FEELINGS INTO WORDS

NAME AFFECT WHEN IT'S IN THE ROOM: ESP W CHILD AND TEEN CLIENTS, WONDER AND GUESS.

"I'M TRYING TO IMAGINE HOW UPSETTING AND HUMILIATING THAT MIGHT FEEL"

"I WONDER IF PART OF THE REASON YOU ARE DISTRESSED IS THAT YOU TRIED, AND NO ONE NOTICED?"

"SOMETIMES IT'S JUST TOO HARD AND LONELY."

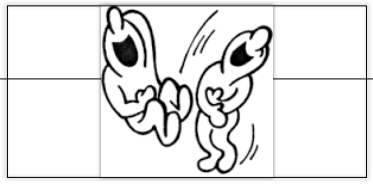
SELF DISCLOSURE TO GIVE CLIENT A VIEW OF IMPACT ON YOU

THERAPY OF MUTUAL RECIPROCAL INFLUENCE

I TELL CLIENTS I'M WORRIED, MOVED, EXCITED, SAD, FRIGHTENED ETC FOR/ABOUT THEM.

UNBIDDEN TEARS, DELIGHT, ANY AUTHENTIC VISCERAL RESPONSE CAN BE SIGNIFICANT "NOW MOMENTS" ARE ALL ABOUT SHOWING UP THIS WAY

NOT TO OVERDO, NOT TO MAKE IT ABOUT YOU, NOT TOO FREQUENTLY USED, BUT ENOUGH SO YOUR EMPATHIC HEART IS KNOWN TO THEM.



LAUGHING AND CRYING IN THERAPY: ATTACHMENT BEHAVIORS?

LAUGHING WITH CLIENTS

- RIGHT-TO-RIGHT BRAIN ATTACHMENT BEHAVIOR FROM INFANCY ON
- CAN ENHANCE ATTACHMENT BONDS
- CAN DEFEND AGAINST ATTACHMENT BONDS
- DIFFERENT EXPERIENCE FACE-TO-FACE VS LOL
- LAUGHTER AND "NOW MOMENTS" (STERN)

GO BEYOND TECHNIQUE AND THEORY, WHEN MUTUALLY RECOGNIZED AND RATIFIED, WILL BRING "A NEW INTERSUBJECTIVE STATE INTO BEING."

LAUGHING WITH CLIENTS

- CONTAINS ELEMENTS OF SURPRISE, UNPREDICTABILITY, AND REPRESENT A "NON-LINEAR JUMP"
- NEGATIVE USES: MASKS HOSTILITY, DIVERTS, FORECLOSES TRUE THOUGHTS AND FEELINGS, CAN HURT OR OFFEND, INTENSIFY RESISTANCE, SEDUCE, ENTICE INTO COMPLIANCE, CONFUSE PATIENT ABOUT INTENT.
- COUNTERTRANSFERENCE ENACTMENTS PLAYED OUT IN GUISE OF HUMOR

LAUGHING WITH CLIENTS

- SOME LAUGHTER REPRESENTS DELIGHT IN MUTUAL RECOGNITION OF TRANSFORMATION
- SOME IS A DEFENSIVE RESISTANCE TO GROWTH AND CHANGE
- CAN BE A FORM OF CAREGIVING, AFFECT REGULATION
- OR COMPULSIVE CAREGIVING USED TO ENTERTAIN AND UP-REGULATE DEPRESSIVE AFFECT IN THE OTHER, OR TO OVERSTIMULATE SOMEONE NEEDING DOWN-REGULATION
- ABSENCE OF LAUGHTER CAN BE SAFE HOLDING…OR MISATTUNEMENT
- HUMOR, JOKES, LAUGHTER AT BEGINNING ARE MORE AFFILIATIVE BEHAVIORS

THINK ABOUT YOUR CASES

- LAUGHTER AS CONNECTION
- LAUGHTER AS DISCONNECTION
- LAUGHTER AS CAREGIVING AND AFFECT REGULATION
- LAUGHTER AS A WAY TO ESTABLISH/MAINTAIN THERAPEUTIC ATTACHMENT

CRYING IN THERAPY

- CRYING AS CONNECTION AND CRYING AS EMOTIONAL RELEASE (E.G., GIVE AVOIDANT CLIENT PERMISSION AND THEY BECOME MORE ADAMANT THEY DON'T WANT TO CRY)
- CRYING: "COME HERE, I NEED YOU"—APPEAL FOR COMFORT/PROTECTION
- NOT ALL CRYING IS THE SAME: FOLLOWS BOWLBY'S INFANT PROGRESSION: TEARS OF: PROTEST, DESPAIR, GRIEF… DETATCHED TEARLESSNESS

CRYING WITH CLIENTS

- WHEN AND WHY MIGHT IT BE GOOD TO ENCOURAGE CRYING, AND WHEN MIGHT IT BE DETRIMENTAL?
- WHAT TYPES OF CAREGIVING AND CONSOLATION DO YOU USE---WORDS, GESTURES, FACIAL EXPRESSIONS, COMFORTING SOUNDS, SILENCE?
- WHT ARE THE CONSEQUENCES OF LEAVING OUT THE MOST BASIC FORM OF HUMAN CAREGIVING AND COMFORT—TOUCH—BECAUSE BOUNDARIES PROHIBIT IT?

CRYING BY THE THERAPIST

- AS INVOLUNTARY SELF-DISCLOSURE
- AS REENACTMENT OF CAREGIVING FROM CLIENT—CAN THREATEN THE PATIENT'S ABILITY TO RELY ON YOU AS A CAREGIVER—ROLE REVERSAL
  - EARLY ON, PATIENTS CAN SEE THIS AS OUR NEEDINESS
  - "AREN'T I ONE WHO IS SUPPOSED TO BE CRYING HERE?"

THINK ABOUT YOUR CASES

- NOT CRYING CAN BE OUR OWN DEFENSIVE AVOIDANCE TO PROTECT OURSELVES
- CRYING AS CONNECTION—OUR EMPATHIC CARE, SOLIDIFIES THE ATTACHMENT BOND—INTERSUBJECTIVE NATURE OF CRYING TOGETHER
- CRYING AT TERMINATIONS
- CRYING DURING ACUTE GRIEF REACTIONS
- HOW DO WE, AS CAREGIVERS, FEEL ABOUT CRYING IN SESSIONS, AND WHAT DOES IT MEAN TO US?

WRAPPING UP

THE THERAPIST DOESN'T HAVE TO BE SECURE AND FREE OF A TOUGH CHILDHOOD, BUT HE/SHE DOES HAVE TO BE SELF-AWARE AND SELF REFLECTIVE

KNOW YOUR TRIGGERS/ COUNTERTRANSFERENCE PULLS AND DO YOUR OWN WORK!

THE MORE SECURE YOU ARE, THE BETTER THE TREATMENT WILL BE AS THE TEEN MOVES TOWARD YOUR WAY OF LOVING AND RELATING AND PROBLEM SOLVING

STRONG AFFECT (BOTH POSITIVE AND NEGATIVE) CAN INDICATE LIMBIC CONNECTION AND ATTACHMENT—NOTICE AND DEVELOP THOSE MOMENTS!