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THE EVOLUTION IN THE WAY OF UNDERSTANDING COUNTERTRANSFERENCE AND ITS EMBEDDING IN THE TRENDS OF PSYCHOTHERAPY

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Summary

The article reviews the ways of understanding the countertransference in currents trends of psychotherapy, including the changes and differences in its definition. Conscious of his own psychic phenomena psychotherapist can analyze countertransference during the session, the descriptive stage of material of the session and on the supervision meeting, and material transference - countertransference is one of a kind to obtain changes in the process of psychotherapy. The authors this paper assumes that the experience of countertransference occurs regardless of paradigm, in which psychotherapists invest their professional activity. Visible in the various currents trends of psychotherapy differences, concern the naming of the phenomenon and the importance attributed to the countertransference in the process of change. Sigmund Freud in *The Future Prospects of Psychoanalysis* described the countertransference as the transference of the analyst in response to the transference of the patient [2] as unconscious, neurotic was considered undesirable in psychotherapy. In the fifties of the twentieth century, recognized the need to broaden the definition to determine what the reactions of the therapist are: conscious, realistic and in response, not only to the transference of the patient. This article follows the evolution of the meaning of the concept of countertransference and practical implications of these changes. Way to presentation of phenomenon assumes the presence of this phenomenon in processes: emotional, cognitive and somatic.

Key words: psychotherapy, psychotherapist, countertransference, therapeutic relationship

Introduction

Psychotherapy which is an intentional action, restoring well-being and health to the patient by affecting the psyche, has several characteristics that differ it from counseling and other forms of support.

In the foreground there is a therapeutic relationship, on the basis of which the therapeutic alliance is formed, the contract (setting) containing a realistic goal, and the subjectivity of the person of the patient. Psychotherapy is defined taking into account the object of interactions, methodology and consequence in the practical layer and the consistency and completeness of

theoretical rules [1]. These latter factors are clearly associated with the flow represented by the therapist.

The origins of psychotherapy can be found in medicine strongly connected with the religious context, astrology (in the Middle Ages incompatible with the teaching of the Church), anthropology (the beginnings found in ancient cultures) and philosophy [1].

The proportions in identifying the factors affecting human development and the course of their adult life, are the basis of mainstream psychotherapy. This element shapes thinking about the essence of disorders and the process of rebalancing.

Modern psychotherapy developed on the basis of hypnotic experiments of Jean Charcot (he examined and described the phenomenon of post-hypnotic suggestion) and the psychoanalytic theory of personality and the concept of unconsciousness formulated by Sigmund Freud [1]. Until this day, psychotherapists make use of his work: the interpretation of the resistance of the patient, the method of catharsis, dream analysis, free association, slips of the tongue and mistakes and transfer.

The attention of the authors of this review is drawn to the phenomenon of countertransference, which focuses on the experience of the therapist.

The importance of the relational context is emphasized on various degrees in different streams of psychotherapy. Regardless to this, the experience of the thrill of the session seems to be common to all therapists, the emergence of associations, memories and thoughts and feelings flowing from the body, the content of which is a reflection of the inner world of the therapist and the space of the patient - therapist.

The importance of psychotherapeutic relationship in the main areas of theoretical trends

Descriptions of development, personality disorders and substance show the complexity and the ambiguity of human nature and the processes that govern it. The boundaries of the concepts used in psychotherapy get blurred by the common roots and theoretical penetration. Regardless of the theoretical content of the trend, the process of psychotherapy contains interwoven aspects: technical (strategies, interventions) and relational (attitudes, emotions and the way of their expression) [2]. The impact of the relational aspect is more difficult to define and determine its impact on the processes and effects of psychotherapy. We can find the therapeutic alliance defined as:

a) prerequisite needed to start psychotherapy,

b) the basic process of inducing the change or

c) the source of the content covered during the session [3].

The perspective view of the therapeutic relationship that is the role of the context in which countertransference locates, encouraged the authors of this article to present the differences in

the perception of the therapeutic relationship in psychotherapy.

The development of psychoanalysis has enriched the techniques for accessing blocked experiences, desires, and feelings of the patient. They began to analyze the defense used by the patient and to use the field for transference - countertransference for designing interventions, correcting the emotional experience of the patient.

The psychoanalytical trend is a diverse system of psychotherapy. In addition to Freud's theory of drives, the analytical theory of the Ego, psychoanalytic psychology of the "I", the theory of the relation with the object has also gained popularity [2]. The assumptions of defense mechanisms, unconscious motivations and structures educated in the early stages of development remain common. The central role belongs to the therapeutic relationship, which is the means to achieve the desired changes of the patient. The therapeutic relationship consists of: working alliance (expressing the agreement of the therapist and patient concerning the goals and objectives that allow realizing the goals of the therapy), the actual relationship and the configuration of the transfer ("unreal" relationship) [2]. The key importance is attributed to the latter one, it is in fact the source of the content interpreted by the analyst. Accepting the patient's experience and the ability of "cognitive processing" of the emotional material, is a challenge and determines the nature of the activity of the psychoanalyst: "... an analyst combines a free account with free emotional reactions and does not perceive their feelings as a problem because they are compatible with the meaning that they understand. Very often, however, the emotions aroused in them are much closer to the heart of the matter than their reasoning, in other words, the unconscious perception of the unconscious patient is tougher and closer than the conscious idea about the situation" [4, p.29-30].

The attitude of the psychoanalytic therapist includes the restraint in the gratification of the neurotic desires of the patient. Frustration experienced by a patient escalates until the climax, which is the transference neurosis. The interpretation of this experience at the session allows the patient to gain insight into the genesis of distortion dominant in his relationships and work them through with the systematic analysis of transfers.

Other, necessary to obtain the change in the characteristics of the therapist are: neutrality to the parties of the conflicts involving the patient and the attention and curiosity in observing the process of the patient [2]. The sense of responsibility and commitment of the therapist, increasingly is also defined as the ability to build effective relationships in an empathic, which helps the therapist in designing the strategy to change.

Cognitive-behavioral concepts derived from the theory of conditioning of Pavlov, Skinner and Hull and Wolpe's hypotheses where dysfunction was understood as an effect of learning, constant pattern of behavior (depending on its content: the habit of restlessness,

emotional or mental) [5]. The focus on the behavior and environmental conditions has evolved including the essential for mediating phenomenon of self-regulation - cognitive and social experiences.

In the sixties, the ideas from social psychology were introduced to the cognitive-behavioral psychotherapy. The interpersonal context affecting learning and behavior focused attention on the therapeutic relationship as a factor involved with modifying pathological cognitive and behavioral patterns.

The actual therapeutic relationship in the cognitive – behavioral mainstream can be used in three ways: as a tool to increase the effectiveness of techniques, source of information on the reality of the patient and how to influence the behavior and cognition of the patient [2]. Although cognitive – behavioral therapists do not find any change in the therapeutic relationship factor, they are increasingly using it to build positive expectations towards the therapy, strengthening the confidence in the therapist and the modification of beliefs and response of the patient to the therapist, which may begin a change in the interpersonal relationships of the patient in their natural environment.

The component of the therapeutic relationship in the described trend is trust, cooperation and the patient's motivation: "The list of important qualities in a therapeutic relationship is enriched with the willingness to cooperate by the cognitive - behavioral therapy (...). Due to the fact that many patients come to the therapy expecting that their role is passive (please put some order into my life), therapists often have to familiarize patients with the expectations of mutual cooperation" [6]. The therapist is clear, active and uses confrontation to the patient, indicating their action sabotage change, but despite their directing role during the session, the patient is left with the decision of what to change.

Thanks to the success of Aaron Beck, Albert Ellis and Albert Bandura, rational - emotive behavior therapy (REBT), cognitive therapy (CT) and Cognitive - behavioral therapy (CBT) have a group of followers in the modern psychotherapy. [7]

In the forties of the twentieth century the humanistic mainstream appeared in psychotherapy, expressing opposition to the psychoanalytical and behavioral description of the human nature and disorders. The developers of the approach focused on the values, the meaning of life and autonomy of the human person: "The basic material of psychotherapy is always this kind of existential pain, and not, as it is often believed, repressed instincts or not quite accurately buried shells of the tragic past" [8].

The phenomenological-anthropological or humanistic-existential approach is implemented, among others, in: Rogers' theory (therapy focused on the person), Frankel's theory (therapy of

sense - logotherapy), Laing's theory (existential therapy) and Perls' theory (Gestalt psychotherapy).

An active therapist cares about the principles of cooperation, not directing and restraint in diagnoses and interpretations, stimulates the client to self-reliance in learning about themselves and correcting attitudes. The tool of the changes are choices, and the client's willingness to self-realization, in terms of responsibility for their behavior, decisions and course of therapy. The use of the term "client" instead of "patient" is characteristic. The therapy session is a meeting of the "here and now", requiring the skills of the therapist to clarify the client's statements, "reflecting" feelings expressed by them and the willingness to "lose oneself" in the reality of the client.

In the humanistic psychotherapies, the leading role belongs to the real relationship, which is a goal in itself, the basis of the contact and the factor contributing to the growth of the client's awareness. The therapist creates an atmosphere that allows the existence of the therapeutic change, and this is possible due to "favorable conditions" mentioned by Rogers [9], e.g. the therapist's characteristics: empathy, consistency and the ability to have positive attitudes. Empathy requires the adoption of internal reference system of the client, consistency requires authentication in communicating with the client, and unconditional positive attitude - differentiating between the man and his behavior. Hence, it is important to perceive their own response and recognition, whether they relate to the reality of "here and now" or are echoes of the past.

On the basis of these trends, there are now individual interpretations of therapeutic achievements. Their projects highlight the influence of psychoanalysis, humanistic or cognitive-behavioral approach. Unequivocal classification of schools of psychotherapy would be simplistic, such as Transactional Analysis of Eric Berne (influence of psychoanalysis), or neuro-linguistic programming (inspired by Gestalt therapy, the similarity of methods for behavioral therapy). The richness of the concept is discovered by systemic therapies such as the structural, strategic and Milan model [10], which is a reflection of the social change after World War II. The systemic therapy initiated by Levy, Minuchin and Spitz [5], combines the pathology of the unit with disturbed family relationships. The inspiration to it was a systems theory of Ludwig von Bertalanffiego dealing with the circularity of interactions of elements in the system (people in the family) and the dynamics, structure and mechanisms of self-regulation, that is the ones restoring homeostasis. The therapeutic work is carried out with the participation of all, accessible family that is called "the patient."

Eclecticism, which is present in psychotherapy, demonstrated the need for exploration and use of new perspectives. The interpenetration of the inspiration of various currents is also reflected in this article, devoted to the ways of adapting countertransference.

The development of the concept of "countertransference" in the mainstream

The analysis of defense and transfers, the study of functions and mechanisms of the ego and the therapeutic actions awakening unconscious awareness, were ahead of the countertransference analysis, which as a therapeutic tool of psychoanalysis, appeared relatively late. Understanding of this phenomenon is not uniform, the basic differences concern the definition of capacity and assessing the utility of countertransference (therapeutic work with a patient with a specific diagnosis) [5].

Sigmund Freud defined the unconscious countertransference response of the therapist, which is the result of unresolved conflicts and the ongoing frustration with the therapist's personal life, manifested as attitudes, reactions and feelings. Countertransference started by a relationship with the patient would, therefore, have the same appeal to personal experience as the patient's transfer. Freud at the source of countertransference saw as primarily oedipal problems of a psychotherapist, who should be aware of their existence and eliminate them from psychoanalysis. An experienced clinical therapist with access to the analysis of training and knowledge of the phenomena accompanying the process of psychotherapy is able to actively counteract the impact of their processes on the course of therapeutic work with the patient and, thus, fulfill the demand of Freud.

The change of the attitude towards countertransference in the fifties of the twentieth century gave birth to many uncertainties, bringing both broader and more useful look at this phenomenon, and due to that they began to be treated as a useful tool in the treatment of patients with disorders deeper than neurotic [5]. The perspective, which describes countertransference as conscious and unconscious feelings, bodily reactions and fantasies revealing the personality of a psychotherapist, was described as the "total" view of countertransference [2]. It launched doubts, as to the scope of the recognition of the phenomenon, it is difficult to conclude that countertransference being one of the forms of the therapist response to the contact with the patient, is synonymous with the general term "reaction".

The broad definition of countertransference initiated efforts to diversify the therapist's response:

a) conscious, arising from the common reality during the session,

b) unconscious response to the transfer of the patient,

c) derived from the past relationship of the therapist and their unresolved conflicts.

The therapeutic relationship has the same attributes as any interpersonal relationship: distortion, falsification or over-interpretation. All reactions of the therapist (including the patient-induced

transfer) may be the communication distortion due to the inclusion of the subjective filter. This knowledge underscores the importance of the therapist in the process of self-therapy and supervision. Undertaking, during self-analysis, the subject of conflicts and fears, makes it easier to make contact with their own ignorance and effectively prevents assigning them to the patient [4].

Paula Heimann participated in the broadening of the concept of countertransference saying about the emotions of the analyst induced by the behavior of the patient [11]. In this way, the activity of the therapist in formulating a constructive interpretation of the patient has been enriched with a study of their own countertransference reactions as "the most important tools of their work," examining the unconsciousness of the patient [4].

Racker continued Heimann's idea by introducing the term countertransference as compatible and complementary [12], where the first one is the identification of a therapist with the subjective state of the patient or their representation of the self, and complementary countertransference - the identification of the object representation of the patient, designed for the therapist.

The present in literature divisions of countertransference reactions complement the basic model with the distinction between chronic and acute as well as subjective and objective countertransference . The chronic one is the constant tendency of the therapist to respond to patients in a way resulting from the unresolved problems , unmet needs or trends . Sharp countertransference, however, is a response dictated by the specific terms of the contact, relational variables and relates to certain patients [2]. Both acute and chronic countertransference threatening psychotherapy must have risen the concerns of psychotherapists against revealing any emotion in relation to the patient. This situation is quite well reflected by the interpretation of Heimann: " Freud's statement, that the analyst must recognize and control his countertransference, does not lead to the conclusion that countertransference is a disturbing factor and that the analyst should become disconnected and without feelings, but they must use their emotional reactions as the key to the unconscious patient. This will protect them from entering the stage as a co - actor" [4, p.32].

The notion of objective and subjective countertransference is close to chronic and acute countertransference [2]. These distinctions reflect the division of the therapist's reaction to the predictable, which result from the patient's interpersonal style (objective countertransference) and specific to the therapist, or the transference reactions (countertransference subjective). Taking into account the original definition, subjective countertransference is closer to the classical approach, involving the presence of the transfer of the patient and the therapist's transference reactions.

If we assume that the projections of the patient and the psychotherapist's internal conflicts fall within a specific interaction in the therapeutic process , the therapist's task would be to distinguish these components from each other. The contribution of the patient in the countertransference may differ greatly , depending on their psychopathology . Subjective countertransference is characteristic of neurotic patients who project their demanding superego over the therapist. Objective countertransference and projective identification mechanism apply to seriously disturbed patients, at the level of personality [11]. On this occasion , the role of countertransference in the therapeutic work with borderline patients is worth mentioning. Projections directed towards the therapist can cause a wide spectrum of countertransference reactions. Among the most common is irritation and anger with a consequent guilt , along with the physiological components, helplessness and fear of losing their own identity. Psychotherapists notice provocation and the tendency to cross borders of the setting with borderline patients, but they also confront with their own reactions , deviating from accepted standards: prolongation of the session , postponing fees , disclosure of the details of the personal life. Sometimes crossing borders is based on rationalization, particularly with patients threatening to commit a suicide [11] or mutilating in a risky way. Therapists using the induced representation of the patient - the victim, fantasize about rescuing the patient and they are willing to satisfy their current suffering. Working with borderline patients richly illustrates countertransference as cognitive, emotional processes, physiological reactions and behaviors performed during the session and beyond it.

The analysis of countertransference allows you to experience the reality of a psychotic patient who is not able to verbally lead the therapist to their world, as does the neurotic patient. The psychoanalyst, understanding their countertransference, recognizes the mechanism of projective identification and is able to better reach the unconscious patient. "This involves short-identifying with the patient and, therefore, experiencing the conflicts and tensions, in a way, from the inside (a phenomenon which Kohut emphasized calling it *a substitute introspection*). If, for a moment, we will feel as the patient feels, we will much more clearly understand why they do what they do and the easier it will be to accept. But for this tool to be effective, we must be able to quite clearly demarcate what is ours from what is external, assign the feelings to us, the patient, the process of psychotherapy" [13].

The evolution of the concept of countertransference in psychoanalysis proceeded from classical, talking about the unconscious, unfavorable therapeutically therapist's transference reactions over the transference patient's material to the total view captivating countertransference as conscious and unconscious, transference (as a function of the unsolved problems and conflicts of the therapist) and non-transference (rational, objective) body,

emotional, and cognitive response of the therapist to the transference and non-transference functioning of the patient.

Currently, we can assume that countertransference is a reaction of the therapist to the transference and non-transference material of the patient [2]. Complementing of this definition is the division of countertransference reactions by Bouchard, Normandin, Lecours [14] into 3 types:

a) objectivity – rational with neutral significance for the course of psychotherapy,
with an observing, distanced therapist;

b) reactive, which is a defense with the negative impact on the process of psychotherapy;

c) reflective, suitable for the therapist and patient due to provided information and the opportunity to develop the insight.

The therapist, who is able to spot and confront themselves with their countertransference feelings towards the patient, learns the patient through their own sensations. The failure of countertransference results in the patient's resistance, inhibition, exterior reaction and even resigning from psychotherapy.

Examples of adaptation of countertransference in psychotherapeutic practice

The description of views on countertransference in psychoanalysis is the starting point for the development and embedding of the countertransference in the wider therapeutic practice. The theoretical basis of the phenomenon, which is applicable in psychoanalytic therapy underwent transformation, entering new areas of therapeutic work. Psychotherapists of other trends, interested in the meaning of their attitude, a way to respond and their role in the therapeutic process could seek a different language describing the experience of contact with the patient or use the classic basics. Presented below is a modest, compared with the multiplicity of available studies, review of the interpretation, indicating the presence of countertransference in the deliberations, research and clinical practice beyond the psychoanalytic framework.

Transactional analysis, describing the social activity uses three ego states : the ones of a Child, Adult and Parent containing a set of behavior patterns . The Parent Ego is a reflection of the functioning of (implementation of specific behaviors, views, experiencing feelings) a parent or another, significant for the development of the child, person. The Adult Ego allows you to make independent assessments of the external world, impartial decision-making or uttering convictions , while the Child Ego illustrates the motives and reactions in a manner characteristic of childhood [15]. Transference and countertransference, in this view, are identical with the dialogue between the patient and the therapist conducted within the "games" [16]. The patient, according to the classical definition of transfer (contact with important objects in childhood), communicates from the position Me - the Child to which an aware of transfer

occurrence psychotherapist reacts from the position Me - the Adult. This kind of action is to stimulate the patient's Adult Ego state , instead of consolidating maladaptive patterns of relationships from the position of the Child. The author also claims that "... if the therapist comes to their patients in a deeply empathetic way, countertransference is in some sense inevitable and perhaps necessary" [16]. The argument emphasizing the usefulness of countertransference is to gain knowledge about the inner world of the patient , if the therapist is able to consciously control the use of their game for their own purposes. The examples are "saving games " generating the patronizing attitude of the therapist, convinced of their own superiority, realizing the need for domination [17]. The profits of this kind will help the therapist to soothe the helplessness and powerlessness that appears, for example, in the response to the resistance of the patient. Such undergone psychotherapy does not meet its primary task - does not serve the patient and is likely to end in failure .

Examples of games used by therapists, observed and mentioned by J.A. Kottler [18], are subordinated to the building of the authority of the psychotherapist, realizing their therapy vision, masking the actual contact with the patient or the therapist protection by moving the therapist's responsibility for the lack of the effects of psychotherapy. The more accomplished they are, the more they confirm the existence of difficult for the therapist countertransference responses.

Transaction games are supported by unsuccessful therapies and working with so-called "difficult patients". The element which determines the occurrence of transactional games in the therapeutic relationship is the Dramatic Triangle [19], indicating the interaction of the roles of the Persecutor, Rescuer (Savior), and Victim. The basis of the games used by therapists are common beliefs about the role, but above all personal experiences that reach the needs, feelings and beliefs that describe the importance of the therapist as a person. Particularly important are the transfers, which the therapist resonates by complementary countertransference, carrying the same game [20].

The probability of the occurrence of the games is greater at the beginning of the therapy and their meaning is weakened with time. This dynamics is influenced by the precise wording of the contract and thorough knowledge of the therapist in the field of transactional analysis enriched with experience. Honest observation of their attitude to the session, participating in the supervision to facilitate getting awareness of ongoing games saves energy and increases the effectiveness of the work of the therapist.

Also, systemic therapy , on the basis of the post-Milan school of L. Boscolo and G. Cecchin, uses essential in the process of psychotherapy identification of games and rules prevailing in the family. Formulating hypotheses , circularity and neutrality are the basic

principles of a family psychotherapy session. Based on the information that the psychotherapist has at a given stage of psychotherapy, they put the system functional hypothesis, which is useful regardless of whether it is true or not and includes all family members and previous generations . The therapist's role focuses on finding the node, the amendment of which, will change the whole system. Family games can last due to the loyalty of each member. It is characteristic that the game which takes place within the family also takes place between family members and the therapist. Gianfranco Cecchin describes this type of phenomenon on the basis of the treatment team that repeats family patterns, changes them when it becomes aware (after the intervention of the supervisor), thereby gaining the ability to use it as an element to the family intervention. " ... Not only did therapists respond by mimicking patterns of the client, but also in a personal way. Each person has their special way to respond to aggression, depression, the situation of exploitation of one person by another, a situation in which one is posed as the victim, grooming , etc. In fact , the therapist responds in their own style , in a manner dependent of how they notice the situation and by their own prejudices and bias" [21, p.37]. The natural tendency to respond based on their own experience with people appears at sessions of psychotherapy. Cecchin believes that both the therapist's flexibility and willingness to confront their own ideas with others, as well as the rigid defense of their position , can be used in therapy. This is done by calling their reaction (feelings, tendencies) and formulating questions to the client, for example, about the similarities in the way of such a response to other known persons, the meaning of the response to the therapist and the possible impact on the change in the course of therapy.

Using the emotional, cognitive and physical responses of the therapist becomes possible, and particularly valuable, through the awareness of their presence and sources. The meaning of, understood in such a way, countertransference in the systemic treatment is described by Cecchin's words: "When we recognize the existence of objective reality, we think that what we see is independent of us as observers. Our way of looking at it is underused then. But, if we constantly undergo the reflection of the distortion of the patient and our own one, we will create a dynamic interaction that goes beyond the issue of neutrality and social control" [21, p.39].

Beliefs close to the ones of Cecchin are presented by constructionists – objectivity is impossible in the process of working with the family. The therapist is building its own version of reality, supported by individual belief systems [10]. This is another example which, although not expressly speaks of countertransference, but it clearly draws the context of subjective filter used by therapists working with families.

The way of understanding and using countertransference in cognitive psychotherapy seems surprising. Contrary to the common opinion of neglecting the relational aspect as a

source of information about the patient, cognitive therapists use both transfer and countertransference, particularly in the work with patients who take more serious forms of disorders.

Considering the point of view of cognitive psychotherapy for the therapeutic relationship, it is important to keep in mind the language of social cognitive psychology which describes the phenomenon as a source of mental disorders. An example to it is the concept of relational schemas that define the representation of the 'I', the representation of the 'You' and the pattern of interaction between me and another person, the so called interpersonal script [20]. The script is closely linked to the way of predicting the relationships with other people and the attitude to this contact. Cognitive psychotherapy focuses on the dysfunctional assumptions (intermediary beliefs) due to their impact on information processing, forming attitudes and experiencing emotions. The transfer is an automatically activated and used mental representation of an important person in the process of interpreting the behavior of the newly met person , which is a common phenomenon and, as such , does not constitute pathology [22] whereas its content, rigidity, and emotional and social effects determine the importance of the transfer for a particular person.

During the sessions of psychotherapy, the patient presents specific beliefs about the person of the therapist, the source of them can be the induced mental representation of an important person from the patient's past [23]. If the therapist does not understand, does not recognize the content of the transfer and confirms the schemes presented by the patient, their work is doomed to failure – it repeats the perturbed model of the patient's functioning in interpersonal relationships. This is one of the reasons why the process of therapy is not progressing at the expected rate.

Other factors contributing to the emergence of resistance from the side of the patient is: the perception of changes resulting from the therapy as threatening to people close to the patient, secondary gains of the presented symptoms and the perception of their role in psychotherapy through the prism subjected to the influence of the therapist. On the psychotherapist's side, in addition to responding in accordance with the transfer of the patient, inaccurate wording of the contract and the therapist's dysfunctional beliefs about themselves in the role of a therapist, the way of conducting psychotherapy, the patient's characteristics or the nature of the world and humans [23]. Of course, of paramount importance is at what stage of education the therapist is, their professional experience and current difficulties of everyday life. The essential role, however, is the patient's behavior which constitutes a catalyst for the cognitive schemes of the therapist, containing their personal experience.

In the cognitive psychotherapy, as in other trends there is the idea of mindfulness to the feelings and thoughts generated by the patient in their verbal and non-verbal transmission. Conscious experience of the contact with the patient is a source of knowledge about automatic thoughts and negative beliefs of people remaining in the therapeutic relationship. The activity of the therapist should focus on verbal and non-verbal signals emitted by the patient as well as self-monitoring.

For the therapist, a signal of the activation of the patterns in their relationship with the patient is the crossing of borders by the therapist in relation with the patient or the consent of the therapist for analogous behavior of the patient [24]. In these cases we are dealing mostly with the schemes of sacrificing ourselves, seeking approval, absolute standards to ourselves and / or other people. Another subtle sign is the lack of involvement of the therapist in the contact with the patient. The scheme of suppression or emotional deprivation will determine the behavior of the therapist: excessive theorizing or expressing criticism of the patient's displays of emotion at the session. The starting point for the assessment of such behaviors is the internal scheme of the therapist, beliefs constituting the theme for the presentation of certain attitudes, not consciously used therapeutic strategies.

Phenomenological – existential psychotherapy, due to the therapist – patient relationship "here and now", enriches the concept of countertransference sensations coming from the body. The authors of this review found it valuable to look beyond psychotherapy focusing on psychological processes and used examples dealing with the somatic manifestations of countertransference.

Merleau – Ponty's phenomenology of perception has become the inspiration in this field, it rejects Cartesian dualism [25]. The body of the therapist, as a receptor may provide information about the reality of the patient and the importance of the relationship with the therapist, like any other countertransference material (feelings, associations and thoughts). In this example, Robert Shaw refers to the experience of Field, who applies the term "embodied countertransference', Samuels, Radley and Mathew, who speak about "somatic countertransference" as well as the concept of Rowan, which enriches the understanding of transference and countertransference with the term of "binding" as a form of somatic empathy, carnal communication of bodies.

Shaw examined therapists who represented mainly the humanistic trend. For the analysis of somatic sensations focus groups and individual interviews were used. The reactions flowing from the bodies of the examined therapists have different severity, there was the tendency to focus attention on the uncomfortable sensations, which could accentuate difficult moments in the process of psychotherapy. Also, the quality of the therapeutic relationship reflected the

carnal reactions of the therapists, who clearly recorded the somatic sensations relations, which engaged them emotionally much more.

The results allowed the derivation of conclusions showing the existence of the corporeal dimension of the process of psychotherapy and the therapeutic relationship, regardless of the present trend. The hypotheses about the greater awareness of the body of humanistic therapists have not been confirmed. Interpreting one's own feelings through the psychotherapeutic prism enables the construction of hypotheses about patients for a specific relationship and the tests, according to the author, cannot be generalized. Experiences described by the tested therapists come from their bodies, not from the bodies of patients.

Another example of the attempts to explore the phenomenon of somatic countertransference is the research described by Booth, Trimble and Egan [26]. The authors used the descriptions of countertransference expressed in four ways: feelings which are the response to the client, fantasy during a therapy session or after its completion, dreams, directly or indirectly related to the client's behaviors, and physical sensations involving stimulation [27]. Somatic sensations may be helpful within the meaning of unconscious processes, human organs have the ability to react to the content, even if they are presented subliminally [28]. The involvement of the therapist in the session is connected with experiencing the relationship in a multi-sensory way and reflecting as a therapeutic tool may induce embodied countertransference.

Booth, Trimble and Egan used the scale, "Egan and Carr Body-Centred", constructed on the basis of the TSI Trauma Symptoms Inventory [29]. The studies were devoted to demonstrating the frequency of symptoms of embodied countertransference with representatives of various therapeutic orientation. The most often experienced symptoms, with more than 50% of the respondents, were: muscle tension, drowsiness, yawning, crying, sudden changes in the body and headaches. The least frequently occurring symptoms are genital pain (2%), sexual arousal (11%) and numbness (15%). Less than 15% of the respondents reported the occurrence of these symptoms in the past six months, nobody of the surveyed population experienced them "often". Despite the detailed account of demographic variables in the study of the researched population, there was no significant relationship between the experience of embodied countertransference and variables. The profitable research is, undoubtedly, demonstrating the possibility of measuring the embodied countertransference with the quantitative method. The matter of normalization of countertransference reactions as the treatment which increases the effectiveness of psychotherapy remains open. Certainly, the muscle tension embodying countertransference may be the inspiration to study the frequency with which this phenomenon is experienced by the therapists in order to minimize the negative impact on their well-being.

This part of the review must mention the prospect of bioenergetic analysis of Alexander Lowen, who, like Freud, was of the view that countertransference is an echo of the history of the therapist [30]. Transference and countertransference go beyond the purely psychological processes, they appear during the session in the form of psychosomatic phenomena, and ignoring them is a threat to psychotherapy.

This phenomenon of the physiological resonance is the basis to empathy and is based on the functioning of the so-called mirror neurons and the process of physical exchange at the molecular level. The research in neuroscience, psychology, and developmental psychology of emotion (especially in terms of attachment theory), implemented since the 90s, indicates that the understanding of interpersonal relationships is based on unconscious and unverbalized touch.

The contemporary therapeutic practice of Vita Heinrich- Clauer is also based on it [31]. The primary aspect of somatic psychotherapy is the bioenergy interpretation of the body (observation , questioning the patient, touching muscles), in which a personal , subjective kind of diagnosis is manifested . Building the somatic space in the therapeutic relationship is done via the perception of physiological sensations. The body of the therapist responds to the patient's physical reality, reveals feelings and reactions related to the temperature , hunger, tension or energy level, which directly reveal the patient's non-verbal material . The patient is not responsible for the sensations that involve the therapist , but they often feel relieved when the way the therapist responds matches their ideas or insights that they have towards themselves. The therapist is looking for the sources of the problem, initiates building the relationships with the patient and starts the therapeutic process. The resonance of the patients' unconscious material may pose a risk for mental and physical health. Frequently experienced, by the author, feelings from patients , exhaustion after the session, or succumbing to patients lasted until, together with the practice of the profession, she gained confidence and set clear boundaries . Trusting one's own perception and bodily resonance is the tool to exit this danger – it must be used as a catalyst for the sake of the therapeutic process. Heinrich- Clauer does not specify the nature of the tool which she uses. The presented experience of the therapist can be considered as :

a) somatic resonance to the reality of the patient , where the therapist is a specific detector of the emotional blockages and energy of the patient;

b) countertransference in the classic sense emphasizing the biographical material of the therapist;

c) expressing the poor practice of the therapist, lack of experience, difficulties and uncertainties concerning the activities undertaken during the session.

Non-verbal techniques used therapeutically form a separate and increasingly popular form of contact with the patient. It is of particular importance in the field of mutual transfer of emotional burdens which elude the conscious control through the non-verbal nature of communication. Psychotherapy based working with the body undertakes assumptions regarding the therapeutic relationship, which can, to some extent, be established non-verbally by adjusting to the characteristics of the patient motion. Movement as a symbolic language may reflect the processes taking place in the unconsciousness, and physical improvisation allows the patient to experiment with new ways of responding [32].

Literature relating to the therapy through movement (DMT-Dance Movement Therapy) [33] does not take a clear position towards the source of countertransference and shows the disjoint concepts of countertransference, the concept of somatic countertransference and their role in the therapeutic relationship. Body and movement are the basis of communication and somatic countertransference is the tool to facilitate getting information about the patient and to manage the dynamics of the session in the therapeutic process. The role of traditionally understood countertransference and the, linked to it, historical material of the therapist is clearly reduced.

Conclusions

From the presented review of the ways of understanding countertransference emerges a picture of the phenomenon, which, despite the attention devoted to it, in the opinion of the authors still leaves much room for interpretation.

Regardless of the therapeutic paradigm, psychotherapists experience cognitive (thoughts, memories, associations), emotional and bodily contents.

The same phenomenon is described in terms of processes harmonizing with the theoretical assumptions of the trend: cognitive patterns, distortions in perceiving the relationship "here and now" or unconscious matrixes in relationships.

Considering the, included in this text, scientific description, one can make some hypotheses about experiencing the relationship by the therapist. The first of these, the best established, directly links to the classical understanding of countertransference as the therapist's reaction, being the image of their conflicts, in the form of the transference' material. This understanding directs our attention toward the subjective reality of the therapist, their relationships and experiences of the past, recorded at the cognitive level (beliefs, thoughts, associations) and the emotional level together with the somatic component.

The broad understanding of countertransference, called "total", includes all conscious and unconscious feelings, bodily reactions and fantasies that are revealed by the personality of the psychotherapist towards the transference and non-transference patient's material. This interpretation may seem too voluminous as a synonym for the overall reaction of the therapist

to the patient. Rarely noticed are the following terms: chronic and subjective countertransference, expressing a constant tendency of the therapist to respond with their own transference material and sharp and objective countertransference that are the function of the patient's individual style and contact conditions. Currently, it is most commonly accepted that the therapist's countertransference is the reaction to the transference and non-transference patient's material.

The reactions of the therapist to the patient's non-transference messages present themselves as less useful in the process of psychotherapy, emphasizing limited experience at work, showing the necessity of self-therapy of the psychotherapist and participation in the professional supervision. What is definitely more valuable are the therapist's responses to the transference patient's material, which is an expression of their subjective reality and the nature of the problems. By analyzing the content of countertransference, therapists can obtain orientation in terms of the patient's psychopathology [11], it may also be possible to confirm this empirically [34].

The somatic aspect of countertransference seems to be the least understood. The human body is physiologically associated with emotional reactions and feelings, the strong experiences of the therapist, activated by transferring the patient, certainly give the answer in the body of the therapist. From the presented papers on the somatic aspect of countertransference emerges the picture of consonance of the therapist and the patient at the somatic level, as a reaction independent of conflicts, unsolved problems and the therapist's experiences which may be the function of their empathic style of building the relationship.

There is no methodologically and empirically substantiated evidence to interpret bodily reactions of the therapist as a reflection of how people react to a patient in their natural environment. This point of view puts the body therapist in the role of a tool encoding information about the patient's social relationships. This hypothesis appears to refer to the, made by Winnicott, concept of objective countertransference in the somatic issuance of this phenomenon. Open remains the question whether the available for the therapist intuitive, emotional, cognitive and somatic tools can become an instrument to draw representative conclusions regarding the reality of the patient and how to shape the conditions that could make it possible.

This review constitutes for the authors the introduction to the exploration of the topic, especially in terms of getting information about the patient's psychopathology and their social reality through the somatic, cognitive and emotional experience of the therapist.

Bibliography

1. Janus D. *Historyczne początki psychoterapii. Psychoterapia w teorii i w praktyce.* Psychologia.net.pl, psychological portal
http://psycho.home.pl/public_html/portal/search.php?level=psychologii.

2. Gelso CJ, Hayes JA. *Relacja terapeutyczna.* Gdańskie Wydawnictwo Psychologiczne, Gdańsk 2005.

3. Prochaska JO, Norcross JC. *Systemy psychoterapeutyczne. Analiza transteoretyczna.* Instytut Psychologii Zdrowia, Warszawa 2006.

4. Heimann P. *On counter-transference* International Journal of Psychoanalysis, 1950, 31: 29-30; 81-84 in Levy ST, Furman AC. *Influential Papers from the 1950's.* Karnac, London 2003.

5. Grzesiuk L. *Psychoterapia teoria,* cz.1, Eneteia Wydawnictwo Psychologii i Kultury, Warszawa 2005.

6. Padesky CA, Greenberger D. *Umysł ponad nastrojem*. Wydawnictwo Uniwersytetu Jagiellońskiego, Kraków 2004, p.18.

7. Ellis A. *Terapia krótkoterminowa*. Gdańskie Wydawnictwo Psychologiczne, Gdańsk 1998

8. Yalom ID. *Kat miłości*, Wydawnictwo Czarna Owca, Warszawa 2009, p.17.

9. Rogers CR. *Terapia nastawiona na klienta. Grupy spotkaniowe,* THESAURUS – PRESS, Wrocław 1991.

10. Goldenberg H, Goldenberg I. *Terapia rodzin.* Wydawnictwo Uniwersytetu Jagiellońskiego, Kraków 2006.

11. Gabbard GO, Wilkinson SM. *Przeciwprzeniesienie w terapii pacjentów borderline.* Wydawnictwo Imago, Gdańsk 2011.

12. Racker H. *Transference and Countertransference.* Karnac, London 1982.

13. Milska–Wrzesińska Z. *Psychoterapia indywidualna w poszukiwaniu zasad uniwersalnych czyli o nowym konserwatyzmie* in Santorski J. *Ciało i charakter: diagnoza i strategie w psychoterapii somatyczno-charakterologicznej. Antologia (wybór i opracowanie).* Jacek Santorski & Co, Warszawa 1995, p.117.

14. Lecours S, Bouchard M, Normandin L. *Countertransference as the therapist's mental activity: Experience and gender differences among psychoanalytically oriented psychologists.* Psychoanalytic Psychology. 1995; 12(2):259-279. obtained from: http://psycnet.apa.org/journals/pap/12/2/259/

15. Berne E. *W co grają ludzie? Psychologia stosunków międzyludzkich*. Wydawnictwo Naukowe PWN, Warszawa 1994.

16. Jagieła J. *Psychologiczne gry transakcyjne jako pułapki w procesie psychoterapii*. Presentation at Scientific Conference: *Gry i symulacje jako przedmiot i metoda badań w naukach społecznych*. Collegium Civitas, Instytut Studiów Politycznych PAN, Warszawa 29-30.11.2008r. http://www.eat.ajd.czest.pl/uploads/images/jagiela1/Jagiela-1.html

17. Suchańska A. *Trójkąt dramatyczny i gry ratownicze*. in Santorski J. *ABC psychologicznej pomocy*. Jacek Santorski & Co Agencja Wydawnicza, Warszawa 1993.

18. Kottler JA. *Opór w psychoterapii.* Gdańskie Wydawnictwo Psychologiczne, Gdańsk 2007.

19. Karpman S. *Drama Triangle Script Drama Analysis.* Transactional Analysis Bulletin 1968; 7 for Jagieła J. *Psychologiczne gry transakcyjne jako pułapki w procesie psychoterapii*. Presentation at Scientific Conference: *Gry i symulacje jako przedmiot i metoda badań w naukach społecznych*, Collegium Civitas, Instytut Studiów Politycznych PAN, Warszawa 29-30.11.2008r. http://www.eat.ajd.czest.pl/uploads/images/jagiela1/Jagiela-1.html.

20. Antons K. *Helf oder Lieben? Trennung und Scheidung in psychosozialen Berufen*. Reinbek, Rewohlt Verlag, 1987 for Jagieła J. *Psychologiczne gry transakcyjne jako pułapki w procesie psychoterapii* - Presentation at Scientific Conference: *Gry i symulacje jako przedmiot i metoda badań w naukach społecznych*, Collegium Civitas,

Instytut Studiów Politycznych PAN, W-wa 29-30.11.2008r. http://www.eat.ajd.czest.pl/uploads/images/jagiela1/Jagiela-1.html

21. Cecchin G. *Mediolańska szkoła terapii rodzin. Wybór prac*. Collegium Medium UJ, Kraków 1995, p. 37; 39.

22. Andersen S, Berenson K. *Spostrzeganie, uczucia i pragnienia – rola poprzednich związków w obecnych relacjach interpersonalnych.* in Forgas J, Williams K, Wheeler L. ed. *Umysł społeczny. Poznawcze i motywacyjne aspekty zachowań interpersonalnych.* Gdańskie Wydawnictwo Psychologiczne, Gdańsk 2005.

23. Chrząstowski S. *Sposób ujmowania relacji terapeutycznej w psychoterapii poznawczej.* Psychoterapia. 2007; 1(140):15-25.

24. Eshkol R, Bernstein DP, Young J. *Psychoterapia skoncentrowana na schematach.* Wydawnictwo Zielone Drzewo IPZ PTP Warszawa, 2011.

25. Shaw R. *The embodied psychotherapist: an exploration of therapist' somatic phenomena within the therapeutic encounter*. Psychotherapy Research. 2004; 14.

26. Booth A, Trimble T, Egan J. *Body – centred. Counter-Transference in a Sample of Irish Clinical Psychologist.* The Irish Psychologist, 2010.

27. Field N. *Listening with the body: An exploration in the countertransference. British Journal of Psychotherapy* for Booth A, Trimble T, Egan J. *Body – centred. Counter-Transference in a Sample of Irish Clinical Psychologist.* The Irish Psychologist, 2010

28. Foroni F, Semin GR. *Language that puts you in touch with your bodily feelings: The multimodal responsiveness of affective expressions.* Psychological Science. 2009; 20(8) for Booth A, Trimble T, Egan J. *Body – centred. Counter-Transference in a Sample of Irish Clinical Psychologist*. The Irish Psychologist, 2010.

29. Briere J, Elliott DM, Harris K, Cotman A. *Trauma Symptom Inventory: Psychometrics and association with childhood and adult trauma in clinical samples.* J InterpersViolence. 1995; 10:387-401. Abstract obtained from: http://jiv.sagepub.com/content/10/4/387.short.

30. Lowen A. *Radość.* Wydawnictwo Czarna Owca, Warszawa, 2010

31. Heinrich-Clauer V. *Körperliche Phänomene der Gegenübertragung. Therapeuten als Resonanzkörper,* Forum der Bioenergetischen Analyse. 1997; 1: 32-41.

32. Pędzich Z., *Psychoterapia tańcem i ruchem*. in Grzesiuk L, Suszek H. *Psychoterapia. Szkoły i Metody.* Eneteia, Warszawa, 2011.

33. Vulcan M. *Is there any body out there? A survey of literature on somatic countertransference and its significance for DMT* s. 275- 281. The Arts in Psychotherapy, Elsevier. 2009; 36(5).

34. Betan E, Heim AK, Zittel Conklin C, Westen D. *Countertransference Phenomena and Personality Pathology in Clinical Practice: An Empirical Investigation.* Am J Psychiatry. 2005; 162(5):890-898.