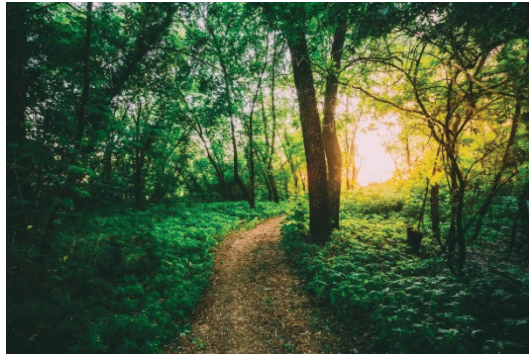


AN EXPLORATION OF BODY-CENTRED COUNTERTRANSFERENCE IN IRISH THERAPISTS

LOUISE HAMILTON, BARBARA HANNIGAN, JONATHAN EGAN, TIM TRIMBLE, CASEY DONAGHEY AND KRISTIN OSBORN



ABSTRACT

This paper aims to assess the frequency of Body Centred Countertransference (BCT) in a large sample of therapists (N=175; 122 Females) using the Egan and Carr Body Centred Countertransference Scale. BCTs are bodily responses of the therapist towards the client's story. Understanding how the body reacts and if gender or therapeutic approach has an impact on the presence of BCTs will help in the management of these symptoms. The most commonly reported BCTs in the current study included: muscle tension (80.6%), tearfulness (77.7%), sleepiness (72%), yawning (69.1%) and throat

constriction (45.8%). Descriptive statistics showed a higher occurrence of muscle tension and aches in female therapists while a higher occurrence of sexual arousal was seen in male therapists. The sample size did not allow for comparison across therapeutic orientation. These theoretical understandings of countertransference will aid in the awareness of BCTs, internal supervision of what this means in session, and its management within the supervisory relationship.

INTRODUCTION

Body-centred Countertransference

The original term Body-centred Countertransference (BCT) comes from a description given by Pearlman and Saakvitne.¹ They stated that: "We hold our affects physically and we will respond unconsciously through our bodies to the material and the presence of our clients. It

is not unusual for a therapist to experience somatic symptoms that parallel her client's body experience".^{1(p.91)} Much of the research on BCTs has used different terms that equate to BCT. Some of the terms used within the literature include embodied CT^{2,3} somatic CT⁴, somatic resonance⁵ and embodied empathy⁶.

Shaw⁷ reported that understanding this bodily phenomenon aided relational engagement with clients when the therapists used their BCT reaction in an attuned way. If the timing was right and if the therapist was acting in the interests of the client, rather than out of a personal CT reaction, then their understanding and use of their BCT aided engagement with clients. Blackburn and Price's⁸ description of 'presence in therapy' supports the notion that a therapist being both present and having a mindful dual awareness related to the relationship helps the therapeutic outcome. Being fully present to the client, bringing one's whole self (knowing what is mine and what is thine from moment to moment) into the relationship.

These reactions can have negative consequences to the therapist's health, for example, aches in joints,⁹ so the awareness of the factors attributing to the presence of BCTs is essential for the management of the therapist's health. Hayes, Gelso, Goldberg, and Kivlighan¹⁰ completed three meta-analyses in their review of countertransference (CT) and its management in psychotherapy. They found small to medium effect sizes in relation to the relationship between CT reactions, management of the CT and therapeutic outcome, with management factors diminishing CT reactions and resulting in better therapy outcomes. This is important in relation to supervision considerations and practice. They called for further focused research in relation to the effects of different types of CT on therapeutic outcomes, as well as how latent variables such as gender, ethnicity and therapists' qualities also impacts these outcomes.

An Irish study of body-centred or somatic CT in 78 clinical psychologists¹¹ found that the majority of the psychologists reported high levels of BCT when in session with

their clients in the previous six months (as measured on the Egan and Carr Body-Centred Countertransference Scale⁹). This level of somatic CT was very similar to that found by Egan and Carr¹² in a sample of 35 female trauma therapists working with adult survivors of childhood abuse and neglect. Higher levels of BCT were found to be related to higher levels of sick leave in female trauma therapists, but this relationship was not found in Booth and colleagues' sample of psychologists who were not primarily working with trauma survivors¹¹. The six most common symptoms reported in more than half of the samples were sleepiness; yawning; muscle tension; unexpectedly shift or movement of part of the therapist's body (hypnic jerk), tearfulness and headaches. These symptoms all occurred in the previous 6 months during a clinical session with a client.

From an Affect Phobia perspective¹³ the inability of a therapist to effectively engage with their own affective state, or the client activating previously unmet needs in the therapist, might result in the manifestation of defensive care-giving.¹⁴ This can

develop into a self-sacrificing style of caregiving in the long-term. Either process may activate the threat or inhibition system (fight/flight/freeze/flag/faint) where muscle tension is likely to occur, without access to a real physical or emotional escape. A therapist's unconscious defences when (automatically) deployed, might include reactions such as; defensive tiredness (switching to immobilization when anger cannot be asserted), somatization (commonly headaches or GI upset¹⁵) and dissociation (hypnic jerks such as unintended bodily shifts or mind drifting into a trance like state).

In a study by Hayes, Nelson and Fauth, 18 therapists were investigated about their experiences of CT reactions and how this impacted therapeutic outcomes.¹⁶ Half of the therapists reported their CT reactions to be 'successful' in the therapeutic outcome. The other half judged their reactions to be 'not successful'. Hayes and colleagues did not find reports of somatic reactions in the therapists studied. However, the interview schedule that they used did not specifically ask the therapists

about reactions in their bodies. Their research found that therapists who reported successful outcomes tended to be better at managing their CT reactions.

Egan and Carr recommended taking a moderate stance in relation to therapists' somatic or BCT responses to their clients,¹² assessing any occurrence in the last 6 months as well as investigating when there was a high occurrence of BCTs in the past 6 months. They found that the therapists reported dissociative responses to clients such as a loss of voice and throat constriction in approximately a third of therapists. McGrath and Egan¹⁷ in a randomised control design of 50 therapists, found that somatic countertransference occurred at the same time as both cognitive and emotional countertransference in response to a video clip of a narcissistic client compared to a neutral control video. These self-report measures showed evidence for somatic responses but did not correlate with the galvanic skin response and heart rate of therapists measured.

A further exploratory study looked at the frequency of occurrence of BCT in clinical psychologists from a variety of therapeutic approaches¹¹ using the same measure. Clinical psychologists ($N= 87$) were sampled to assess whether there was a relationship between BCT and a range of variables including: primary client group and therapeutic orientation; clinical supervision; client session hours per week, age, marital status, sick leave, number of children and number of years post-qualification. Results showed that there was no significant relationship between BCT and these key variables. Booth and colleagues¹¹ suggested that future research needs to replicate their study's findings, thereby providing further support for their results and additionally exploring whether there is a gender effect across frequency and type of BCT occurrence.

Several studies have suggested that there are gender differences in CT. Studies have shown that male therapists are more likely to withdraw from clients when their CT is evoked.^{18,19,20} Female therapists, on the other hand, are more likely to become over-involved with their clients when their

CT is aroused.¹³ The two previously mentioned Irish studies in relation to BCT in female trauma therapists and clinical psychologists did not assess gender effects.^{19,20}

Analytic Case Studies

There are a number of published analytic case studies which explore the topic of BCT.^{21,22,23,24,25,26,26} Of particular interest is the work of Dosamantes-Beaudry²³ who explains the importance for therapists to attend not only to their clients' nonverbal somatic communications, but also their own. She argues that this knowledge then enables therapists to understand an evolving intersubjective relationship between themselves and their clients more fully and accurately. According to her, the therapist's somatic CT is an additional source of information for the therapist which, to be employed most usefully, needs to be integrated with cognitive and emotional CT as well.

According to modern attachment theory the ability of the therapist to assuage the unmet needs of insecurely attached clients is achieved by the attunement of the therapist to the clients' elicited help

seeking behaviour, which is often non-verbal and is expressed in micro glances and other verbal and non-verbal signs displayed to a care-giver.¹⁴ Affect Phobia Theory¹³ adds to Heard and colleagues stance by stating that adaptive affect and closeness needs which have been un-responded to, or inconsistently responded to, or in some cases verbally or physically punished, may result in an unconsciously phobic resistance to approaching adaptive affect and sharing distress with potential care-givers. In O'Laoide, Osborne and Egan,²⁷ in a large sample of young Irish adults (N= 761), insecure attachment was assessed in relation to depression, anxiety and stress. This relationship appeared to be mediated by levels of current depersonalisation. Those who experienced emotional maltreatment and neglect had significantly higher levels of depersonalization than those who reported experiencing childhood physical or sexual abuse.

Stone⁵ suggested that there are three conditions that are most likely to lead to embodied CT. He proposed that if the client has a borderline or psychotic

personality structure, they are more likely to project their embodied feelings onto the therapist. Also, if the client has instinctual problems, childhood, or severe pre-verbal trauma, the therapist may pick this up in their body. And finally, if the therapist has a particular typology, that is, has introverted intuition as the superior function, they are more open to experiencing bodily CT responses. Stone's work has not been validated by longitudinal models.

BCT has also been explored in qualitative studies.^{2,7,28,29} Shaw^{7(p.271)} concluded that "psychotherapy is an inherently embodied process", and that the therapist needs to use their body as part of the psychotherapeutic process. According to Shaw, therapists who experience bodily phenomena note a stronger connection with the client, they are more emotionally involved. Participants in this study indicated that the bodily phenomena of BCT was not addressed in their therapeutic training and that this was a detrimental gap. Booth and colleagues¹¹ also recommended that being conscious of BCT 'as it arises in the moment' during a

therapy session, and whether it affects the connection with the client, is important to explore in clinical supervision. This approach is in keeping with Hayes and colleagues' review of CT, its management and clinical outcomes.¹⁰

METHOD

The current study will use BCT as defined by Pearlman and Saakvitne¹ and utilised by Egan and Carr^{12,20} and Booth and colleagues¹¹ who all used 'The Egan & Carr, Body-centred Countertransference Scale'⁹ as a dependent measure. This study aims to build on previous research, assessing 'The Egan & Carr, Body-centred Countertransference Scale'⁹ in a larger, more diverse population of therapists, taking into consideration the impact of gender and therapeutic approaches.

Design

This study was conducted using a cross-sectional design in order to investigate the Egan and Carr Body-Centred Countertransference Scale.⁹ This research aimed to investigate if there was a

difference in the presence of the 16 BCT symptoms in this scale, with regard to gender and therapeutic approaches.

Procedure

Participants were recruited through various professional bodies including the Irish Council for Psychotherapy; The Irish Association for Counselling and Psychotherapy and the Division of Counselling Psychology of the Psychological Society of Ireland. Therapists were contacted by their organization via e-mail, giving them information about the study and instructions on taking part. They were also contacted by the Research Ethics Committee with approval from Trinity College, Dublin. Each participant received a survey link to an online Survey Monkey™ platform.

Participants

One hundred and seventy-five therapists took part in the study, of which the majority were female (n = 122, 70%). The participants ranged in age from 35 to 72 (Mean = 54.9 years, SD = 9.80) with post qualification experience ranging from 3 to

30 years (Mean = 10.84 years, SD = 6.65).

Table 1 below summarises the distribution of the different therapeutic orientations used by the participants.

Table 1: Breakdown of Participant Therapeutic Approach/Orientation

Therapeutic Orientation	Percentage	Frequency
Psychodynamic	8.00	14
Humanistic	22.86	40
Integrative	56.57	99
Cognitive Behavioural	2.29	4
Systematic	5.14	9
Other	5.14	9
Total N = 175	100	175
Female	70	122

Note. Psychodynamic = Jungian, Object Relations (and the other specialities mentioned); Humanistic = Person Centred and Gestalt; Integrative = Working from more than one therapeutic approach

Measures

The measure used for this study was the Egan & Carr Body-centred Countertransference Scale.⁹ This scale was originally based on the Trauma Symptom Inventory (TSI),³⁰ a scale commonly used to assess trauma symptoms in adults. The Egan & Carr Body-centred Countertransference Scale⁹ is a 16-item scale that was used to evaluate the

frequency of various forms of BCT experienced by therapists in their sessions with clients in the previous 6 months. The frequency of each symptom was responded to on a Likert scale questionnaire. Participants indicated 0 (“never”) if the symptom had not occurred in the previous six months, 1 (“this has happened to me at least once in the last 6 months”), 2 (“this has happened a few times in the last 6 months”) and 3 (“often”) if the symptom has occurred quite frequently in the past six months. The Body-Centred Counter Transference Scale has good internal consistency with a Cronbach’s alpha of .74.

Data Analysis

Quantitative data were analysed using the SPSS Statistics 25.0³¹ programme. Preliminary analysis was used to check that all of the assumptions had been met. Test-retest reliability was used to assess the scale’s reliability. A Cronbach’s alpha of .84 was calculated. One item (numbness) was positively skewed but no improvement in reliability was seen when this item was

removed. Following this, characteristics of the participants were investigated. Responses were assessed to investigate the frequency with which participants experienced the various BCTs in response to clients in the last six months. BCTs were meant to be examined across gender and therapeutic approach but the numbers were inadequate for inferential statistics.

RESULTS

In Table 2. below it shows the percentage frequency with which the sample reported experiencing each type of BCT. The five most common forms of BCT were muscle tension, with just over 80% of the sample reporting this form of BCT in the last six months. This was followed by: tearfulness (78%), sleepiness (72%), unexpectedly shifting body (70%) and yawning (69%) as the most commonly experienced BCT reactions for the sample in the last six months. The least common occurrences of BCT, as reported by the participants were dizziness (20%) and genital pain (7%).

Table 2: Descriptive statistics of sample by gender where BCT occurred at any time in the previous six months

	Female Therapists (N = 122)		Male Therapists (N = 53)		Total Sample (N = 175)	
	Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)
Muscle Tension	105	86.1	36	67.9	141	80.6
Tearfulness	94	77	42	79.2	118	77.7
Sleepiness	87	71.3	39	73.6	126	72
Yawning	83	68	38	71.7	121	69.1
Throat Constriction	64	52.5	16	30.2	80	45.8
Headache	53	43.4	22	41.5	75	42.9
Stomach Disturbance	55	45.1	20	37.7	75	42.8
Unexpectedly Shifting Body	87	71.3	36	67.9	123	29.1
Sexual Arousal	29	23.8	21	39.6	41	28.6
Raised Voice	34	27.9	15	28.3	49	28
Aches in Joints	36	29.5	9	17	45	25.8
Nausea	32	26.2	10	18.9	42	24
Numbness*	29	23.8	10	18.9	39	22.3
Dizziness	29	23.8	6	11.3	35	20
Genital Pain	11	9	2	3.7	13	7.5

*Numbness was removed from the final scale due to skewness

DISCUSSION

The current study replicated the findings of Egan and Carr Body Centred Countertransference Scale⁹, Egan and Carr⁴ and Booth, Trimble and Egan¹¹, highlighting the presence of 16 core BCT symptoms in therapy sessions. The sample size of therapists in this study was much larger, however, the problem of gender and therapeutic orientation comparisons still remained due to small number of participants in these sub-samples. The numbers were too small for a comparison among therapeutic approaches, but descriptive statistics showed some differences in the frequency of BCTs between genders. A higher proportion of female therapists appeared to experience muscle tension, aches, throat constriction and dizziness. In comparison, a higher proportion of male therapists appeared to have experienced sexual arousal. Without an analysis of statistical significance, this can only suggest the need to look further into this. Different gendered reactions to BCTs have been noticed in Hayes and Gelso²⁰ as well as Latts and Gelso.¹⁹ A study with a balanced gender profile needs to be conducted to examine these trends.

Supporting Dosamantes-Beaudry²³ and Shaw,⁷ there was a high frequency of BCT in the participants of this study, highlighting the power of bodily reactions for therapist and client. Similarly to Shaw,⁷ nausea and aches in the body were common experiences for the therapists. Building on Blackburn and Price⁸ and Hayes and colleagues¹⁰, confirming the commonality of these reactions, one can see how this knowledge can enhance the presence of the therapist within session and therefore influence the therapeutic outcome.

Strengths and Limitations of the Present Study

The limitations of the present study include the relatively small sample size, as this did not allow for comparison across gender or therapeutic approach. Future research might seek to explore this further. As per Hayes and colleagues¹⁰ recommendation, future research needs to address whether the presence of BCT has an effect on clinical outcomes and also whether its management improves same.

Separately, the relationship between BCT and vicarious traumatization and burnout have not yet been studied. With larger sample sizes, the use of factor analysis might prove beneficial in addressing whether certain items in the scale cluster to identify, for example, somatization in a therapist and its correlates (See Abbass et al., 2008 for a discussion¹⁵).

As this study used a cross-sectional design, future research needs to include a longitudinal analysis of therapists' BCT and related variables over time. Using in-vivo video analysis of BCT¹³ would also be suggested, evaluating micro-seconds of relational patterns between the therapist and client in order to facilitate the deconstruction of both clients' and the therapists' defences in an ever-maturing dynamic corrective relationship.¹² How BCT affects the attunement/misattunement of a therapist with the client would also be an important area of study.^{13,14,35}

Finally, Hayes's and colleagues¹⁰ called for the management of CT in supervision with therapists. The findings in this current cross-sectional study appear to have

supported their stance. However, analysing the clinical utility and acceptability of this measure with therapists (and clients) needs to be assessed in the future.

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- Casey Donaghey BA,
Trainee Therapist and Teaching Assistant,
National University of Ireland, Galway
- Kristin Osborn,
Psychotherapist,
Trainer and Associate at Harvard Medical,
Harvard University

AUTHORS

Dr Louise Hamilton,
Counselling Psychologist,
The University of Dublin, Trinity College

Dr Barbara Hannigan,
Assistant Professor,
School of Psychology,
The University of Dublin, Trinity College

Dr Jonathan Egan,
Deputy Director of the DPsychSc in Clinical
Psychology,
National University of Ireland, Galway

Dr Tim Trimble,
Assistant Professor Psychology,
The University of Dublin, Trinity College