ARTICLE

Body-Centred Counter-Transference in a Sample of Irish Clinical Psychologists

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Abstract

Recent psychotherapy research has investigated the physical reactions of therapists to their clients and the potential utility of these reactions in therapeutic settings. These bodily reactions can range from nausea and genital pain to headaches. They are collectively known as body-centred counter-transference. The current exploratory study used the Egan and Carr (2005) body-centred counter-transference scale to assess the frequency of body-centred counter-transference in a sample of Irish clinical Psychologists (N = 87). The study looked at the relationship between body-centred counter-transference and a variety of other variables (age, number of children, years' post-qualification experience, sick leave, marital status, client session hours per week, clinical supervision, primary client group and therapeutic orientation). The study found no relationship between body-centred counter-transference and any of these variables ($p > .05$). However, it may be the individual manner in which a therapist engages with and manages the counter-transference manifestation that will determine the effects on the therapist and the therapy.

Introduction

According to Field (1989), counter-transference can be expressed in four ways: evocation of a specific feeling in response to a client; emergence of fantasies during a therapy session or after a therapy session; dreams which indirectly or directly relate to a particular client; and through behaviour which includes the spontaneous arousal of physical feelings. The cognitive and emotional reactions of therapists to client material are well documented (Hayes, 2004). However, therapists have also reported experiencing physical reactions in response to such material. These reactions within the therapist's body have been far less documented than the emotional and cognitive elements of counter-transference (Egan & Carr, 2008).

"Bodily-centred" counter-transference is a little-discussed manifestation of counter-transference where the therapist is spontaneously aroused by the client material through a physical medium (Field, 1989). There is little documentation about these somatic reactions to client material. Therefore, the processes underlying body-centred counter-transference are not fully understood. Stone (2006) and Wosket (1999) described the therapist as having a "tuning fork" vibrating with the client's psychic material through the unconscious to describe the process of somatic reactions. It is suggested that the use of the therapeutic tool, or "self" via postural mirroring, can induce body-centred counter-transference. Postural mirroring of clients is the result of a therapist's unconscious automatic somatic counter-transference (Rothschild & Rand, 2006). Postural mirroring and the resulting body-centred counter-transference can be a very useful way to gain insight into the client's emotional and physical processes. Mohacsy (1995) explored the idea that non-verbal behaviour could give a greater insight into the internal world of the client.

Often the client's body language can instinctively reveal information which they are either deliberately trying to withhold verbally or about psychological processes of which they are not conscious (Mohacsy, 1995). Therefore, awareness of a client's postures and gestures can give the therapist insight into the personal (hidden) emotions of the client. According to Foroni and Semin (2009), people's bodies respond physically to emotion-related material presented aurally, even when it is presented in a subliminal manner. New branches of therapy are embracing the link between bodily reactions and emotions. Theoretically based therapies such as sensorimotor psychotherapy are based on the premise that understanding physical reactions can help in understanding cognition (Ogden & Minton, 2000). In spite of all this, there is still a reservation within the clinical world to accept the study of bodily reactions (Mohacsy, 1995).

Research in the area is far from abundant, although some studies have revealed that the link between physical sensations and emotion is a phenomenon experienced by both clients and therapists. Several therapists have reported experiencing physical reactions to clients in therapy. Bryce Boyer (1993) reported experiencing physical sensations during a therapy session with a severely regressed patient. A qualitative study by Geller and Greenberg (2002) into the concept of "presence" in psychotherapy unveiled that therapists who seek to be fully present in the therapy session experienced multisensory sensations including physical reactions. In this study the therapists reported experiencing, in their body, a resonance of what was occurring for the client in the session and that this bodily receptivity provided them with information and guided their understanding and response to the client (Geller & Greenberg, 2002). It is proposed that what we exhibit in our physical behaviour and sensations can be related to our emotional sense inside our bodies even if that emotion is being held unconsciously (Blackburn & Price, 2007). Therefore, our physical reactions – even if stimulated unconsciously – can give us insight into unconscious processes if we attend to them (Maroda, 1991).

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According to Field (1989), bodily reactions can often be a source of stress and embarrassment for the therapist. However, they can form a vital part of the therapeutic process (Field, 1989). Pearlman and Saakvitne (1995) described these symptoms as "body-centred countertransference". This is the process by which a therapist holds an affect physically and responds unconsciously through their body (Pearlman & Saakvitne, 1995). The symptoms of body-centred counter-transference include: nausea, headaches, becoming tearful, raising of a therapist's voice, unexpectedly shifting of the body, genital pain, muscle tension, losing voice, aches in joints, stomach disturbance, and numbness. However, this potentially useful technique when not monitored can result in the therapist unconsciously taking on the client's internal experience through their physical response (Egan & Carr, 2008). Rothschild and Rand (2006) warn that a contagion of affect – physically, emotionally and cognitively – can result from this unmonitored empathy. While there is a caveat attached to these experiences, Egan and Carr (2008) argue that acknowledgement and understanding of the process of body-centred counter-transference may be beneficial to therapists. Due to the stigma attached to counter-transference reactions, there is a need to analyze the frequency and degree with which this phenomenon is experienced by other therapists in order to normalise reactions, and thereby minimise the negative effects on their well-being.

Counter-transference is an element of all therapies and has an impact on all therapists (Pearlman & Saakvitne, 1995). Therefore, it is important to develop an understanding of the processes involved in order to gain as much positive impact from the inevitable phenomenon as is possible. Egan and Carr (2005) developed a questionnaire to assess the frequency of somatic/body-centred counter-transference in therapists. This scale was used to assess the frequency of body-centred counter-transference in a sample of female trauma therapists. They found a relationship between the frequency of counter-transference experienced and the amount of sick leave taken.

The current study will therefore use the Egan and Carr (2005) scale to investigate the frequency of body-centred counter-transference across a variety of therapeutic orientations used in modern clinical psychology, looking closely at the differences which may be related to the therapists' primary client group and therapeutic orientation. As most previous studies into body-centred counter-transference focus on therapists who work exclusively with trauma victims, the current study will look at the frequency of body-centred counter-transference in a varied sample of Irish clinical psychologists.

Table 1. Participant Demographics

	Mean (SD)	Range
Age	36.5 (6.8)	26–56
No. of Children	0.82 (1.28)	0–5
Years Post-Qualification	7.49 (6.88)	0–30
Sick Leave	3.59 (8.3)	0–71
Marital Status	**Percentage**	**Frequency**
Married	41.2	35
Single	35.3	30
Cohabiting	16.5	14
Separated/Divorced	7.1	6
Client Session Hrs/Wk		
0-5	9.4	8
6-10	23.5	20
11-15	41.2	35
16-20	25.9	22
Clinical Supervision Hrs/Mth		
1 hour or less	32.9	28
About 2 hrs	34.1	29
About 3 hrs	16.5	14
About 4 hrs	16.5	14
Primary Client Group		
Adult	34.1	29
Child & Adolescent	56.5	48
Other	9.4	8
Therapeutic Orientation		
Psychodynamic	12.9	11
Behavioural/Cog. Behavioural	17.6	15
Integrative	23.5	20
Eclectic	25.9	22
Other	12.9	11
Not Specified	7.1	6

Methodology

Participants were a group of 84 Irish clinical psychologists and 3 trainee clinical psychologists currently undergoing placement. Table 1 provides an overview of the demographics of the sample. For the clinical psychologists, the mean duration of post-qualification experience was 7.49 years (*SD* = 6.88). The majority of participants engaged in 11 to 15 hours of client sessions per week. Most participants received "about two hours per month" of clinical supervision.

Instrument

The scale used for the current study was the Egan and Carr (2005) Body-centred Countertransference Scale. This scale was based on the Trauma Symptom Inventory (TSI; Briere, 1995), which is used to assess trauma symptoms in adults. The Body-Centred Countertransference Scale is not intended to give a diagnosis of body-centred counter-transference, but to evaluate the relatl of various forms of body-centred counter-transference in a particular individual. The frequency of each symptom is rated on a four point Likert scale type questionnaire, ranging from 0 (*never*) if the symptom has not occurred in the previous six months to 3 (*often*) if the symptom has occurred quite frequently in the past six months.

According to Egan and Carr (2008), the Body-Centred Countertransference Scale has good internal consistency, with a Cronbach's alpha coefficient reported of .74 for the 16-item scale. In the current study the Cronbach's alpha coefficient was .62. This indicates that the internal consistency reliability of the

questionnaire could be questionable as values above .7 meet Nunnally's statistical criteria for acceptable reliability (Nunnally, 1978). However, the nature of the population that was assessed in the current study (clinical psychologists as opposed to the original scale's sample of trauma therapists) combined with the multifactorial nature of the Body-Centred Countertransference Scale could be responsible for the low Cronbach's alpha coefficient (Bernardi, 1994). The multifactorial nature of the scale combined with the reduced level of response variance within the current sample is considered to be responsible for the reduction in the Cronbach's alpha level, and not a low level of reliability within the scale.

Results and Discussion

The frequency of bodily symptoms experienced by therapists in reaction to their clients over the previous six months is presented in Table 2. Instances of non-occurrence of each item are not stated and figures are rounded to the nearest whole number. The shaded areas represent instances where 'at least 50 percent' of the sample reported experiencing this form of body-centred counter-transference during a therapy session in response to a client at anytime over the last six months.
From the Table 2 it is possible to see that the most common forms of body-centred counter-transference are muscle tension and sleepiness with over 70% of participants reporting having experienced these forms of body-centred counter-transference over the last six months. Yawning was reported in 65%, tearfulness in 61%, unexpected shift in the psychologist's body in 57%, and headache in 53%, all indicating that clinical psychologists in Ireland do experience a reasonably high incidence of body-centred counter-transference. The least reported symptoms of body-centred counter-transference were genital pain at 2%, sexual arousal at 11% and numbness at 15%. Fifteen percent or less of the sample reported having experienced these three symptoms over the last six months and none of the sample reported experiencing these symptoms "often". Egan and Carr (2008) also found that muscle tension, sleepiness, yawning, tearfulness, unexpected shift in body and headache were the most commonly experienced responses, with over 50% of their sample experiencing each of these reactions. This finding suggests that body-centred counter-transference is experienced in some form by the majority of this sample of clinical psychologists in Ireland, with almost 80% of the current sample experiencing muscle tension in the last six months. Egan and Carr (2008) found that 83% of their sample of trauma therapists had experienced muscle tension in the previous six months. The findings also offer some support to the claims of Pearlman and Saakvitne (1995) that body-centred counter-transference is present in all therapists and therapies.

Table 2. Frequency of Occurrence Body-centred Counter-transference

	Body-Centred Counter-transference Symptoms	**1–2 "Has happened in the last 6 months but not often" %**	**3 "Yes, has happened often in the last six months" %**	**Occurring at any time in the last six months %**
1	Muscle Tension	73	6	79
2	Sleepiness	69	7	76
3	Yawning	58	7	65
4	Tearfulness	55	6	61
5	Unexpectedly Shifting Your Body	51	6	57
6	Headache	52	1	53
7	Stomach Disturbance	44	2	46
8	Throat Constriction	32	4	36
9	Raised Voice	33	0	33
10	Dizziness	19	0	19
11	Loss of Voice	18	0	18
12	Aches in Joints	18	0	18
13	Nausea	17	1	18
14	Numbness	15	0	15
15	Sexual Arousal	11	0	11
16	Genital Pain	2	0	2

Note. All figures are percentages of the study sample ($N = 87$).

Associations Between Body-Centred Counter-Transference and Other Variables

A two-way between-groups analysis of variance was conducted to explore the impact of Therapeutic Orientation and Primary Client Group on levels of body-centred counter-transference, as measured by the Egan and Carr body-centred counter-transference scale. Subjects were divided into six groups according to their Therapeutic Orientation (Group 1: psychodynamic; Group 2: behavioural and cognitive behavioural; Group 3: Integrative; Group 4: Eclectic; Group 5: other; and Group 6: Not specified). Primary Client Group was divided into three groups (Group 1: Adult; Group 2: Child and Adolescent; and Group 3: Other).

There was no evidence for an interaction effect between Therapeutic Orientation and Primary Client Group, F (10, 1548) = 0.85, p > .05. The was also no evidence for a main effect for Therapeutic Orientation, F (5, 1548) = 1.21, p > .05, or Primary Client Group (F = 0.216; df = 2; p>0.05). However, these results must be interpreted with caution due to the small sample sizes in each group.

In order to investigate the relationship between body-centred counter-transference and the other variables (i.e., age, years of post-qualification experience, sick leave days), a correlation matrix of Pearson product-moment correlation coefficients was used. Contrary to the findings of Egan and Carr (2008), the current study found no significant relationship between body-centred counter-transference and sick leave days taken (r = 0.062; n=87; p>0.05). Analyses revealed no significant relationship between body-centred counter-transference and age, number of children, or number of years of post-qualification experience. A Spearman's rho correlation matrix revealed no significant relationship between body-centred counter-transference and client session (0-5hrs/wk; 6-10hrs/wk; 11-15hrs/wk; 16-20hrs/wk) and clinical supervision (≤1hrs/mth; about 2hrs/mth; about 3hrs/mth; ≥4hrs/mth). The lack of a relationship between body-centred counter-transference and these key variables suggests that they do not impact upon the experience of counter-transference manifestations. This finding supports Hayes and colleagues' (1998) observation that even therapists deemed "excellent by their peers" experienced counter-transference in 80% of their sessions. In the current study body-centred counter-transference was experienced by therapists regardless of therapeutic orientation and primary client group.

While there is an abundance of research and theoretical debate in the literature on counter-transference, there is very little extant research which focuses on the phenomenon. In some studies in the literature it was referred to as "embodied countertransference" (Field, 1989, p. 513). Samuels (1985) investigated the counter-transference reactions of 30 psychotherapists and found that 46 percent of counter-transference reactions could be described as embodied counter-transference.

One particular weakness of this current study is its failure to assess whether there is a difference in the frequency and type of body-centred counter-transference between female and male psychologists. This was an artefact of the research design, as the primary concern of the current study was not to investigate the gender effects associated with body-centred counter-transference.

The primary implication of the current study combined with the findings of Egan and Carr (2008) is to suggest that somatic or body-centred counter-transference can be measured using quantitative methods. Alongside this, the findings of the present study will aid in the stimulation of debate on the meaning of these reactions. The normalisation of body-centred counter-transference reactions is an integral part in progressing to utilise these reactions effectively in the therapeutic setting.

As this is an exploratory study, future researchers will need to replicate these findings to provide further support for these patterns, and will also need to explore whether the body-centred counter-transference experienced by trauma therapists needs more attention in supervision than in non-trauma therapists. Asking clinicians to rate the percentage of their clients over the previous six months who have experienced trauma, as well as the length of time that the clinician has worked in trauma, and whether the therapist is male or female might assist in this exploration. In addition, further mixed-methods research needs to explore the personal meaning of body-centred counter-transference for clinicians. The prevalence of body-centred counter-transference in this sample of clinical psychologists clearly heralds a new era where this phenomenon needs to be seriously addressed by psychologists.

References

Bernardi, R. A. (1994). Validating research results when Cronbach's alpha is below .70: A methodological procedure. *Educational and Psychological Measurement, 54*, 766–775.

Blackburn, J., & Price, C. (2007). Implications of presence in manual therapy. *Journal of Bodywork and Movement Therapies, 11*(1), 68–77.

Briere, J. (1995). *Trauma Symptom Inventory: Professional manual.* Odessa, FL: Psychological Assessment Resources.

Bryce Boyer, L. (1993). Countertransference with severely regressed patients. In L. Epstein & A. H. Feiner (Eds.), *Countertransference: The therapist's contribution to the therapeutic situation* (pp. 347–405). London: Jason

Aronson.
Egan, J., & Carr, A. (2005). *Burnout in female counsellor/therapists of the NCS: Study II*. Paper resented at the Psychological Society of Ireland Annual conference.
Egan, J., & Carr, A. (2008). Body-centred countertrans-ference in female trauma therapists. *Irish Association of Counselling and Psychotherapy Quarterly Journal, 8*, 24-27.
Field, N. (1989). Listening with the body: An exploration in the countertransference. *British Journal of Psychotherapy, 5*(4), 512–522.
Foroni, F., & Semin, G. R. (2009). Language that puts you in touch with your bodily feelings: The multimodal responsiveness of affective expressions. *Psychological Science, 20*(8), 974–980.
Geller, S. M., & Greenberg, L. S. (2002). Therapeutic presence: Therapists' experience of presence in the psychotherapy encounter. *Person-Centred and Experiential Psychotherapies, 1*, 71–86.
Hayes, J. A. (2004). The inner world of the psychotherapist: A program of research on countertransference. *Psychotherapy Research, 14(1)*, 21-36.
Hayes, J. A., McCracken, J. E., McClanahan, M. K., Hill, C. E., Harp, J. S., & Carozzoni, P. (1998). Therapist perspectives on countertransference: Qualitative data in search of a theory. *Journal of Counseling Psychology, 45*(4), 468-482.
Maroda, K. J. (1991). *The power of countertransference: Innovations in analytic technique*. San Francisco: John Wiley and Sons.
Mohacsy, I. (1995). Nonverbal communication and its place in the therapy session. *The Arts in Psychotherapy, 22*(1), 31–38.
Nunnally, J. (1978). *Psychometric theory* (2nd ed.) New York: McGraw-Hill.
Ogden, P., & Minton, K. (2000). Sensorimotor psychotherapy. *Traumatology, 6*(3), 149–173.
Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton.
Rothschild, B., & Rand, M. (2006). *Help for the helper: Self care strategies for managing burnout and stress*. London: Norton.
Samuels, A. (1985). Countertransference, the "mundus imaginalis" and a research project. *Journal of Analytical Psychology, 30*(1), 47–71.
Stone, M. (2006). The analyst's body as a tuning fork: Embodied resonance in countertransference. *Journal of Analytical Psychology, 51*, 109–124.
Wosket, V. (1999). *The therapeutic use of self.* London: Routledge.

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