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BODY-CENTRED COUNTERTRANSFERENCE IN FEMALE TRAUMA THERAPISTS

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Walker (2004) described how working with adult survivors of trauma and abuse can result in a 'breakdown of the boundary between a therapeutic role and the reality and world view of the therapist. Material from one seeps unacceptably and unmanageably into the other. Abuse breaks in the 'skin' of the person making the boundary between the self and other blurred' (p. 81). The degree to which working with trauma survivors can have negative effects on a clinician has been well documented in the literature resulting in burnout (Egan and Carr, 2005b; Maslach, 1982), vicarious traumatisation (Pearlman & Saakvitne, 1995) and compassion fatigue (Figley, 1995).

The degree to which therapists' bodies react to their clients however has been less well documented. Pearlman and Saakvitne (1995) listed frequently reported symptoms which therapists have described encountering during sessions with clients. They termed these bodily reactions, 'body-centred countertransference'. Common symptoms included; nausea, headaches, becoming tearful, raising of a therapist's voice, unexpectedly shifting their body, genital pain, muscle tension, losing voice, aches in joints, stomach disturbance, and numbness. They postulated that therapists who are unable to remain somatically grounded in a therapy session with a client would be unlikely to be able to bring back a client who is in dissociative state in the counselling room.

Rothschild and Rand (2006) would regard much of the 'body-centred countertransference' of a therapist as unconscious automatic 'somatic countertransference' which is as a result of 'postural mirroring' of clients. Therapists who are not mindful of their postural mirroring can result in an unconscious 'taking on' of a client's internal experience. This can when monitored be a useful technique in developing empathy. However, therapists need to be able to taste a client's reality whilst remaining themselves; 'a periodic quick visit to the client's chair can be useful and give much-needed insight. However, to be able to adequately help our clients, we must remain in our own chair' (p. 201). Postural mirroring therefore is a very useful way to gain information about a client's current physical and emotional process. Rothschild cited recent neuroscience research which demonstrated how 'mirror neurons' in the brain allow us to literally automatically feel the world of another by simply observing them non-verbally and by witnessing their facial expressions (See pages 42-45, Rothschild & Rand, 2006, for a good summary of the process). People tend to unconsciously have 'somatic empathy' for others which allows us to put ourselves in another's place. This empathy if not monitored warns Rothschild and Rand, can result in a contagion of affect both physically, emotionally and cognitively for a therapist or onlooker.

Understanding that somatic or body-centred countertransference exists may be beneficial to therapists, but not knowing the frequency or degree to which other therapists experience it may result in a feeling of confusion as to how 'normal' their degree of and frequency of

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somatic reactions are in relation to their peers. In addition, if a therapist has a significant level of somatic countertransference, what does this mean in relation to their well-being and ability to work with their clients?

In order to answer this, a questionnaire was developed to address the frequency of somatic/body-centred countertransference in therapists. In addition, a therapist's (well-being) was assessed by asking them the number of sick leave days they estimate they had taken in previous year. The degree to which a therapist partook in supervision was also asked so as to address whether supervision may have a protective effect on levels of somatic countertransference.

Female therapists who took part in the study

Thirty five female counsellors of the National Counselling Service (NCS), a service set up to provide counselling and psychotherapy for adult survivors of childhood abuse and neglect took part in the study. This represented 60 percent of the total possible (N=58) female counsellor/therapists who were in the NCS at the time of the study. Please refer to Table 1. below which outlines the therapists' demographics.

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Table 1. Demographics of Counsellor/therapists

	Mean	SD	Range
Age	45	9	31-62yrs
Number of children	1.5	1.6	0-4
Number of years post qualification experience	6	3.5	0-18yrs
Number of year's child abuse experience	5.8	4.7	0.5-24yrs
Number of months working with the NCS	28.7	19.8	1-118months
Sick leave days in last 12 months	4	7.2	0-36days

Marital Status	**Frequency**	**Percentage**	**Primary Health Care qualification**		
Married	18	51%	Nursing	n= 11	31%
Single	10	29%	Psychology	n= 18	51%
Cohabiting	3	9%	Social Work	n= 6	17%
Separated/divorced	3	9%			
Widowed	1	3%			

Post Primary Counselling Qualification[1]	**Frequency**	**Percentage**
Diploma in Counselling	13	37%
Diploma in Family Therapy	6	17%
Master in Counselling Psychology	13	37%
Trainee in Clinical Psychology	2	6%
Certificate in Gestalt Therapy	4	11%
Diploma in Behaviour Therapy	1	3%
Psychoanalytic Training	2	6%
Group Analytic Training	1	3%
Master in Integrative Therapy	1	3%
BA/Masters in Counselling	7	14%[2]
Client Session Hours Per Week		
0-5 sessions per week	1	3%
6-10 sessions per week	6	17%
11-15 sessions per week	22	63%
16-20 sessions per week	6	17%
Clinical Supervision Per Month		
One hour or less	7	20%
About 2 hours	11	31%
About 3 hours	14	40%
About 4 hours	3	9%

Egan & Carr Body-centred Countertransference Scale (Egan & Carr, 2005b).

The frequency to which therapists experienced bodily symptoms in reaction to their clients over the last six months was assessed by asking the 35 therapists to respond to a list of 16 symptoms cited in the therapeutic literature. The scale was based on a common scale used to assess trauma symptoms in adults (Briere, 1995). The frequency of each symptom was responded to on a likert scale type questionnaire. Therapists were asked to respond 0 if the symptom has never occurred in the previous six months, a 1 or a 2 if the symptom has happened in the last six months but has not happened that often and a 3 if it has happened often in the last six months. Table 2. below reports the frequency which the sample of

[1] 9 counsellors indicated that they had completed 2 counselling qualifications following their primary health care qualification and 3 indicated that they completed 3 counselling qualifications following their primary health care qualification

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female therapists reported experiencing each type of somatic countertransference. Percentages have been rounded up and non-occurrence is not stated.

Table 2. Frequency of occurrence of Body-Centred Countertransference in a sample of 35 counsellor/therapists of the NCS

Body Centred Counter transference	Therapists responded with a 1 or a 2 on a Likert scale indicating the symptom 'has happened in the last six months but not that often'	Therapists responded that 'Yes this has happened **often** in the last six months'	Frequency of symptoms occurring anytime in last six months
Sleepiness	66%	26%	92%
Muscle Tension	63%	20%	83%
Unexpected Shift in Body	54%	23%	77%
Yawning	66%	11.%	77%
Tearfulness	57%	14%	71%
Headaches	40%	14%	54%
Stomach Disturbance	32%	9%	41%
Aches in Joints	34%	3%	37%
Throat Constriction	20%	14%	34%
Loss of Voice	29%	3%	32%
Raised Voice	29%	-	29%
Numbness	29%	-	29%
Dizziness	20%	6%	26%
Sexual Arousal	26%	-	26%
Nausea	17%	6%	23%
Genital Pain	6%	-	6%

Shaded items indicated that at least 70 percent of the sample reported experiencing this form of body-centred countertransference at anytime over the last six months when in session in response to a client.

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The internal reliability of the 16 item scale was assessed using Cronbach's Alpha. Cronbach's Alpha for the total of the 16 items is .74. This met Nunnaly's statistical criteria for acceptable reliability.

Number of Days Annual Sick Leave & relationship to supervision. When the total score for each therapist was correlated with the number of sick leave days each therapist had taken, a statistically significant relationship was found between the degree to which a therapist reported experiencing body-centred countertransference and the amount of sick days they reported taking ($r=.400$, $p<.05$). Interestingly, the degree to which a therapist perceived receiving supervision per month was invertly related to the amount of body-centred countertransference reported; suggesting a possible buffering effect from supervision. Please see Table 3 below for results of correlations.

Table 3. Pearson Product-Moment Correlations between number of sick leave days taken and the Total of Egan & Carr's Body-centred Countertransference Scale and Hours of supervision per month

	Number of day's sick leave taken
Total of Egan & Carr's Body-centred Counter Transference Scale	.400*
Hours supervision per month	-.352*

*significant at $p<.05$

Discussion

It appears that somatic or body-centred countertransference can be reliably measured. The results of this study also indicate that there may be a relationship between the degree to which a therapist reports experiencing countertransference at the somatic level in response to their clients and the amount of sick leave they need to take in the previous calendar year.

These initial findings need to be replicated by other researchers. They do appear to support Rothschild's (2006) resolve that therapists need to remain in their own chairs and that if therapists are to be of any help, they need, 'to maintain a sense of calm detachment. Since this person isn't the client, it had better be the professional!' (p. 11).

At a less scientific level, the reporting of body-centred countertransference symptoms by therapists will help to normalise some of these symptoms and at least commence a debate amongst therapists about what each bodily reaction might mean. In addition, the degree to which techniques and supervision can be used to help therapists reduce their reactions will also need to be explored.

These results have not been replicated by other researchers and the degree to which the total of any countertransference scale has benign or malign consequences for therapists needs to be tested against other validated and reliable measures for criterion validity. The authors

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would be delighted if other therapists would like to use the scale in their research and we give permission for its use without needing to make contact for consent to use same.

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