Operationalisation of Countertransference in Positive Psychotherapy

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Abstract
Most examples of countertransference found in literature, refer to the perceived emotional reactions of the therapist, and unconscious components are considered in terms of transitory "blind spots", which may be worked through by gaining awareness of the emotional reactions. Previously, the term "countertransference", as psychoanalytic in origin, used primarily by psychoanalysts. However, now it is recognized by many schools of psychotherapy and applied much more widely.

Today there are two opposite approaches to the concept of countertransference. The first approach can be called "classical." It is characterized by the concept of countertransference, regarded as an unconscious reaction of the psychoanalyst to the transference of the patient. The second approach is called "holistic». In it's light the countertransference is a common emotional reactions of the therapist to the patient in the treatment situation. Despite the fact that the concept of transference and countertransference is about 100 years, the operationalization of these phenomena remains largely insufficient.

In our work of the analysis of countertransference, we rely on the theoretical concepts borrowed from Positive Psychotherapy after Nossrat Peseschkian (1968). According to his concepts, there are four channels to investigate the reality:

1) By means of feelings (emotions, feelings);
2) By means of reason (thoughts, impulses);
3) By means of tradition (associations, memories);
4) By means of intuition (imagination, fears, expectations).

Key words: countertransference, operationalization, positive psychotherapy, balance model.

Typically, most examples of countertransference found in literature, refer to the perceived emotional reactions of the therapist, and unconscious components are considered in terms of transitory "blind spots", which may be worked through by gaining awareness of the emotional reactions. However, the problems of the therapist are not only to discover any unconscious feelings, but also in how to deal with these very intense feelings that the therapist experiences in working with the patients and which will inevitably impact on therapy.

Previously, the term "countertransference", which is psychoanalytic in origin and was used primarily by psychoanalysts. However, now it is recognized by many schools of psychotherapy and is applied much more widely. At the time, when the transference has, in the short term, changed from a major obstacle into a very powerful resource for treatment, countertransference has retained something of a negative image for almost forty years.

A big step forward, in developing the concept of countertransference in psychoanalytic

work, came at a time when it became more apparent how important this phenomenon is and how it might help to provide the therapist with an understanding of the information provided by the patient. Another idea was brought up that psychotherapist has the elements of understanding and comprehension of the processes occurring in the patient's mind and that these elements can not be realized immediately, but can be detected by the therapist through listening to the patient, who is then able to observe his own mental associations. This idea is implicitly contained in description of Freud (1912) on the value of a neutral, or "free-floating" attention. However, the first and a clear statement about the positive significance of countertransference was made by Paola Heimann (1950), and this was then supported by other analysts.

Heimann viewed countertransference as a phenomenon that included all the feelings experienced by the analyst toward the patient. She believed that the analyst must use his/her own emotional reactions to the patient – i.e.: their own countertransference – as a key to greater understanding. The awareness of the therapist's own reactions could thus provide additional access to the recognition of unconscious mental processes of the patient. In the United States, we can point out the work of Harold Searles, who has described, very frankly, the natural countertransferential storms in an article in 1959 (Note: the article focuses on attempts of psychotic patients to infuriate the therapist). In Britain, D.W. Winnicott became known for his courageous process of self-discovery (ref: a well-known 1949 article "Hate in the countertransference") (Winnicott, D.W. (1949).

Today, there are two opposite approaches to the concept of countertransference. The first approach can be called "classical." It is characterized by the concept of countertransference, regarded as an unconscious reaction of the psychoanalyst to the transference of the patient. This approach is closely related to one introduced by Freud's (1910) relation to this term, and his advise to psychoanalysts was to try overcome their countertransference. In this perspective, the origin of countertransference is seen mainly as neurotic; that is as the unconscious conflicts of the analyst.

The second approach is called "holistic" (or totalistic approach). In it's light, the countertransference is the common emotional reactions of the therapist to the patient in the treatment situation. Representatives of this approach believe that the conscious and unconscious reactions of the therapist to the patients in treatment depend on many factors: on the reality of the patient, on transference of the patient, on the realistic needs of the therapist, and (of course) on the neurotic needs of the therapist. It is also important to understand that the therapist, just as any human being, may get angry at some of the client's behaviour – because of real reasons – and not

giving an appropriate response of anger could ultimately be rather harmful to the patient.

All this, in turn, points to the extreme value and importance of the emotional health of the therapist, which is the main instrument of his work. In addition, the second approach assumes that the different components of the therapist's emotional reactions are closely related to each other and, despite the fact that countertransference eventually must be overcome, it still provides immense help in deepening the therapist's understanding of their patients (Goncharov, 2005, 2011).

This second approach is based on a broader definition of countertransference, and calls for a more active technical use of countertransference in therapy. Many representatives of this approach are discussed with the patient and influence their countertransference, seeing it as an important part of psychotherapeutic process. The desire to analyze all reactions towards the patient, sooner or later leads to a more-or-less complete painting in of any ‘white spots’ or unconscious moments. It is useful or even necessary to understand, and be able to analyze, the countertransference, in order to effectively use it in psychotherapy. If the therapist does not do that, he/she can never get that valuable experience and therefore possibly limit their therapeutic options.

Psychotherapists of a 'holistic' persuasion criticize the "classical" position, in that this narrowed definition of countertransference is well suited to conceal its true value, since it implies that, in principle, countertransference is something ‘wrong’ and ‘harmful’. And because of that – as stated further in this kind of argument – a therapist is supported by the phobic avoidance of installation on their emotional reactions that lead to difficulties in understanding the phenomena occurring in the therapeutic situation.

Bilateral infiltration of influences coming from the transference and the reality of the patient, on the one hand, and from past and current reality of the therapist, on the other hand, contains a wealth of important information about non-verbal communication between patient and therapist. This information can be easily lost, if you attempt to remove the emotional reactions of the therapist, rather than to put them together with their sources in the centre of attention. However, if the therapist stands on the opinion that his emotional reactions are important technical tool, which helps obtain better understanding and help the patients, then the therapist will feel much freer to be more open to take emerging transference situations, positive and negative feelings, will have no more need in the suppression of such reactions, and can use them for work.

One important group of patients, especially those with severe pathology of the character and disorders at the borderline or even on a psychotic level, who evidence intensive affect and a rapidly emerging and rapidly changing nature of the transference, often cause very intense

reactions in the therapist's countertransference. These contain important strongholds, which can be used for guidance in understanding what is of central importance in the chaotic manifestations in a patient at the moment (McWilliams, 1998).

As mentioned above, this theoretical innovation made by P. Heimann, who in 1949 presented a paper "On countertransference" at the congress in Zurich (the report was published in 1950). In her speech, P. Heimann quite sharply marked several different positions.

- First, countertransference should be called the total response of the analyst to the patient, the whole of his conscious and unconscious reactions during psychoanalysis.
- Secondly, this response is not only inevitable, but also beneficial, because, when used skilfully, opens the possibility of a more complete understanding of the patient. According to Heimann, the concept of countertransference should go the way of such Freudian concepts as the "resistance" and "transfer" - to move from the category of obstacles to the category of working tools.
- Third, countertransference is a product of the patient as much as, if not more so, as the product of therapist mental activity. It was assumed that a skilled therapist is sufficiently free of neurotic reactions of countertransference, so he is able to distinguish the feelings that came from a patient on their own, and use them as a tool for therapeutic work.

Thus, Paula Heimann has given new life to countertransference and has significantly enriched the tools of modern psychotherapy.

Psychological disorders and the problem of the patients are often depending on and manifest in the sphere of relationship: relationship with oneself, with other people or with the outside world. The person turns out to be in some illusory or distorted reality, because, for various reasons, is not able to perceive the full feedback on his own behaviour, largely due to the fact that he just has no "normal" relationships. In this regard, the therapist is often the only guide of this necessary feedback, provided, of course, according to the condition of its own sufficient communicative competence. Countertransference, as a diagnostic tool, plays an important role in defining the problem to the patient. The therapist should assess what reactions the patient suggests to the therapist through the medium of the proposed relationship, and what the theme of these reactions can be assigned to.

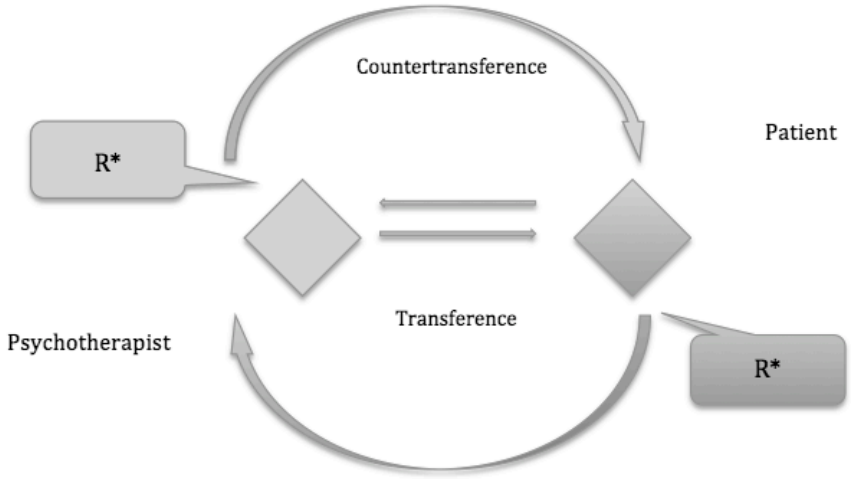
Despite the fact that the concept of transference and countertransference is about 100 years old, the operationalization of these phenomena remains largely insufficient. In particular, there is

no unified model, following which, the experts could formulate their therapeutic experience and analyze their difficulties, and detect "blind spots". At the same time, the need to conceptualize and formulate counter-transference is very acute. With this as a purpose, I want to present a model for operationalization of countertransference. The same model can be used for the analysis of transference (McWilliams, 1998).

Metaphorically, countertransference can be compared to a mirror, in which we are engaged in the process of communication with the client we are looking at and we also have the opportunity to evaluate our own reactions and behaviour. If the mirror is strictly frontal, we can clearly and fully see ourselves, and our reactions. If the mirror is located at an angle, we will likely see ourselves not fully, and not notice our behaviour, but more to see what is happening around us. This option in the location of the "mirror" could be called neurotic or unconscious when the therapist is unable to use own countertransference reactions to analyze the customer's behaviour and emotions because of the "blind" areas. Therapist competence can be regarded as the ability to adjust the position of the mirror in good time.

Similarly, the client looks to us like a mirror. Quite often, in the mirror, he or she sees, not a therapist, but someone significant from the past – via the transference. And, as professionals, we are able to notice that, and have the ability to recognize the significant object of the patient and separate or differentiate ourselves from these objects.

Schematically, the relationship of transference and countertransference can be represented as follows:



* R = an important object from the past.

Figure 1. Transference and countertransference

In telling us about their experiences of relationships with their environment, the patient shows us how he or she interprets this reality, how this qualifies the behaviour of others, as well as his own, as a response to the behaviour of others towards him/her. The client also presents to us the patterns of how he/she experiences others' reactions toward him/her as well as his/her experience in relation to others; we learn the clients' experience of how 'others act towards me' and how 'I act towards others.', This perspective of experience is characterized as transference.

For his part, the psychotherapist finds himself in the role of those "others" and is able to assess whether the therapist's experience of interaction with the patient matches the experience described by the patient in interaction with others. In addition, the therapist can assess whether a patient's experience of self-perception in interaction with others, matches with the therapist's experience of perception of the patient in therapy.

In our work of analysis of countertransference, we rely on the theoretical concept borrowed from Positive Psychotherapy after Nossrat Peseschkian (1968). The method of Positive Psychotherapy is a method of transcultural psychodynamic psychotherapy with a humanistic image of man. This method has been recognized by the World Council for Psychotherapy (www.worldpsyche.org) and the European Association for Psychotherapy (www.europsyche.org) as an independent and scientific modality. In 1997, the method has received an award of Richard Martin-Price for quality assurance.

Arguing about the content of the transference or countertransference, we may note that, in the literature can be found more often mentions of feelings or fantasies. However, these are not a complete reflection of human experiences. For the conceptualization and formalization of therapist experiences, it seemed to us a very practical concept of the four ways of knowing reality, formulated by a German professor and founder of the method of Positive Psychotherapy, Nossrat Peseschkian (1986, 1987). According to his concept, there are four channels to investigate the reality:

1) By means of feelings (emotions, feelings, sensations);
2) By means of reasons (thoughts, impulses, estimation);
3) By means of tradition (associations, memories, personal experience);
4) By means of intuition (imagination, fears, expectations).

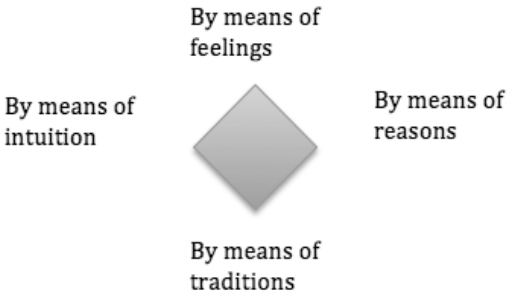


Fig. 2. Four channels for investigation of reality (N. Peseschkian, 1977)

These four channels of investigating the reality we are actively used in interaction with the environment and can be used to conceptualize experience as our own (countertransference), and the experience of the patient (transference) (Goncharov, 2005, 2011).

Given a time continuum, these ways of investigating the world are well differentiated, and cover all the time dimensions: past, present and future. The domain of feelings/sensations and thoughts/impulses are relevant to the present time. That is what experienced here and now. The domain of personal experience and associations feeds from the past. The domain of fantasy/ expectations/fears relate to the future: that is something what has not happened yet.

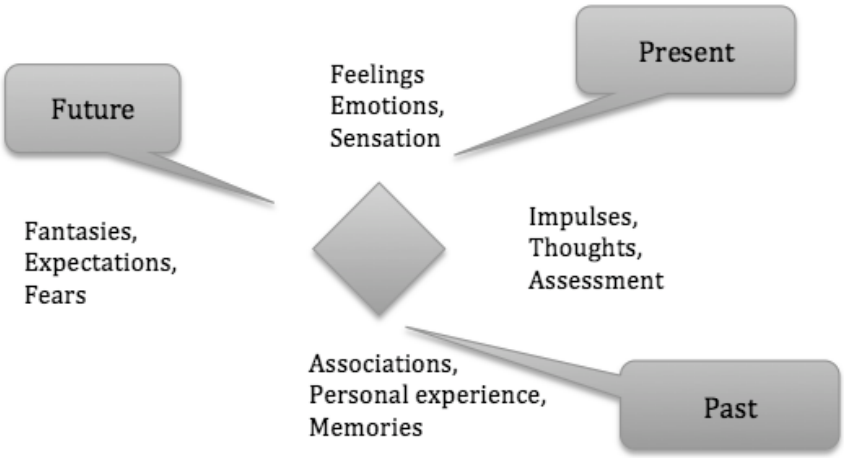


Fig. 3. Four areas for transference – countertransference analysis and three dimensions of time

The analysis of emotional reactions

The significance of emotions in the psychotherapeutic process is repeatedly emphasized in literature by numerous authors. With different patients, the therapist will experience different feelings. With some patients the therapist will experience interest and involvement with some,

anger or boredom with others. With some of the patients, the therapist waits and prepares to meet them, with others, he is forgetful, not alert, or even happy if the patient misses the session. All of these are the countertransferential reactions.

Fig. 4. Area for analysis of emotional reactions

The analysis of emotions and affects is a very important part of any psychotherapy. Emotions indicate the significance of the events and often serve as the key to understanding the content of the conflicts. The availability of emotional reactions is also a valuable diagnostic criterion and effects the formation of the therapeutic perspectives.

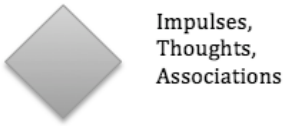
Emotional experiences, that we go through as a psychotherapist, in communication with the patient, can serve as a representation of experiences that may have other objects in the patient's everyday life. The analysis of this area requires the detection of any emotional or physical reactions that occur in interpersonal therapist and patient.

Examples of therapist experiences include:

- Loving-kindness and participation;
- Irritation or anger;
- Emptiness;
- Pity and sympathy;
- Boredom and indifference;
- Annoyance and regret;
- Tenderness and romance;
- Fear or anxiety;
- Resentment or regret;
- Admiration and delight.

This is, of course, just a small range of possible experiences. It is important to figure out an emotional experience without requiring the immediate connection with the cause that creates a binding to these emotions. This can be done later. The attempt to explain these feelings immediately can cause a resistance or activation of defence mechanisms.

Possible questions: How do I feel like with this patient? What happens to my body and



senses while communicating with the patient?

It is worthwhile to be able to distinguish situational emotional experience, caused by the influence of a private experience, and the repeated emotional experiences arising from time to time in conjunction with the patient. The second are obviously more valuable, because they represent a relatively stable pattern of reactions to the patient, and can serve as a representation of the emotional experience of others.

The analysis of cognitive experiences and impulses

The analysis of the domain of logic and reason is no less valuable. Concurrently, it includes an analysis of motives and impulses, thoughts and assessments.

Fig. 5 Area for analysis of cognitive and behavioral responses.

Meeting different clients causes not only different feelings, but also pushes us to behave with them differently. With some patients, we are sympathetic and energetic, and with others, we are passive and pessimistic. With one sort of patients, the session flies by like a flash, and with the other ones 50 minutes can seem like an eternity. All these aspects of our behaviour are also very important to understand what our patient offers to us in a therapy session, and how we can respond to this offer. Communicating with patients, we constantly estimate them, and tell to ourselves something about them and comment.

The ability to capture and analyze our thoughts, impulses, gestures, and the assessments may reveal to us access to a deeper understanding of what is happening with the patient.

In an analysis of this domain, we describe any assessments or thoughts that we give to the patient's behaviour, or our internal motivation towards the patient. Our impulses or motivation toward the patient associated with our estimation of his/her behaviour. For example, a patient who is assessed as "attacking" can cause an impulse to defend, or to make excuses. Or a patient, who is assessed as hopeless, may cause an impulse towards detachment. Possible questions arise: What do I want to do for this patient? What do I think and say to myself about this patient?

Examples of a therapist’s experiences:

- What an unpromising patient = detachment;

- He is deceiving me = suspicious;
- What an unfortunate client = the desire to guide;
- She's just beautiful = flirting;
- He is hiding something or plotting = caution;
- She is making fun of me = attacking, accusing;
- He is accusing me = protection or justification;
- No worries for her = the provision of autonomy;
- How helpless and vulnerable s/he is = the desire to guide and instruct.

A set of emotional and cognitive experiences are relevant to the present time and to describe what is happening right here and now in the psychotherapy session. In the recently released second edition of "Operationalized Psychodynamic Diagnostics - 2" (the OPD-2), there is a list of 32 formalized patterns of relationship based on the 'Circumplex model' of Lorna Smith-Benjamin (1974). They can also be used for the operationalization of countertransference and transference in the area of impulses.

One of the goals of any psychotherapeutic diagnostics is to formulate the dynamics of relationship. According to an idea developed by a group of German scientists and articulated in the "operationalized psychodynamic diagnostics - 2", this dynamic is evident in the four positions marked on the interpersonal Figure 5:

1) The ratio of patients to the behaviour of other
2) The ratio of the patient's own behaviour
3) The ratio of therapist to patient behaviour
4) And the attitude of the therapist's own behaviour to the patient.

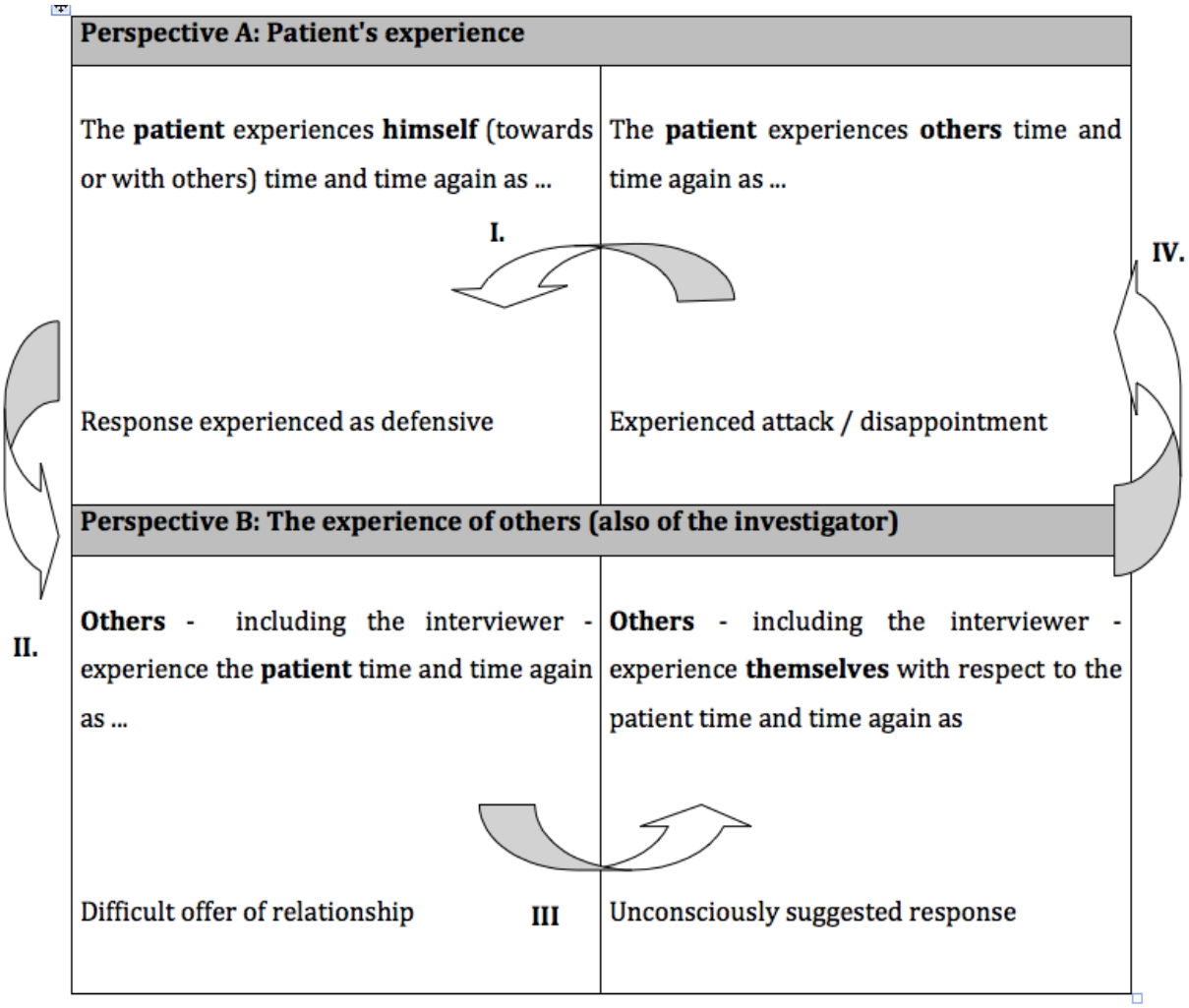


Figure 6: Relationship diagnosis schema according to OPD - 2

Diagnosis should allow a linking together of the four interpersonal positions. This diagnostic goes beyond a pure description of what is happening in the relationship, expanding and deepening it into a dynamic understanding (cf. Grande et al., 2004a). When such a connection is made, it can be guided by the schema presented in Figure 6, in which the typical connections between the positions are shown.

In the patients' experiential perspective, the order of occurrence of events is typically from right to left (I. Relationship dynamic link): The patients describe repetitive ways in which others relate to them, which may be disappointing, unpleasant, or hostile, and to which they themselves inevitably react with their own experience. This means that from the patient's perspective of his experience, more active modes of behaviour are frequently attributed to other persons, more reactive modes to themselves. (I: Dynamic relationship connection)

From the perspective of others, and that of the interviewer, things are mostly exactly the reverse: What the patient describes as his reaction to the object, appears here as a problematic offer of relationship, which challenges, entangles, or puts pressure, etc. on the other person, etc. Most of the time, it is those initiating and active moments in the relationship behaviour, which the patient leaves out in his self-experiencing and which result in a characteristic difference between self-perception and perception by others (link II).

The third (III) dynamic relationship connection links the two lower areas of the diagram, from left to right. With his offer of relationship, the patient is suggesting certain reactions, which can be experienced, in the countertransference, as feelings, fantasies, and impulses to act.

The examiner may now test things out: What would the patient experience if I were to give in to those impulses which he suggests I react to through his offer of relationship. Would he then experience my behaviour in just the same way as he experiences the behaviour of other persons again and again but at other times? This question relates to the link (IV) between the lower right and upper right diagram areas.

If that last connection can be established, so that it agrees with all the other contexts, the interpretation of the relationship dynamic events is complete. It can now be summarized in a condensed formulation: it describes a feedback loop and explains how the patient, by this offer of relationship, produces exactly those reactions that he actually fears and wishes to avoid. The match between the impulses experienced in the countertransference and the patient's experience of his objects forms the decisive criterion for whether the diagnosis of the dysfunctional relationship pattern has been successful (Goncharov, et al, 2011).

Analysis of associations and memories

About this domain of experiences, probably the least that can be said, although it is fairly well known, that the experiences that we have gone through in the past have a deep impact on our perception of the present. An association is a kind of emotional and cognitive connection with the past experiences that comes alive through the actual experience that is happening in the present. Often a patient’s story about his/her life provokes different responses in the therapist, because these are associated with particular attitudes towards those experiences endured in their own lives.

Fig. 7: Area for analysis of personal experience.

Associations can provide access to past experiences, which we had gone through, but that can be repressed. As a rule, it is the experience of relationships with significant others: parents, teachers, relatives, etc. In addition, the experience of painful or other significant situations that we have had to go through, can generate fear of repetition, and can consequently to explain the arising emotions and imagination.

There are possible questions that arise: “What does this situation reminds me of?” “Why have I remembered this story?” Imagine a situation in which your patient tells you that he recently handed back the car, unintentionally hit another car, and damaged it. After that, being scared, he escaped from the scene. Now he feels guilty, ashamed and has regrets about his actions. Keeping in mind that nothing can be changed now, the therapist tries to encourage the patient's ability to recognize own feelings, acknowledge own guilt, his regrets, and being able to verbalize this experience. Therapist wants to support and reassure the patient.

But now imagine that, in the recent experience of the therapist, someone had also damaged his car and has also disappeared from the scene. He had to repair his car on his own. In this perspective, the therapist’s perception of the patient’s history may look a little different and lead to other impressions and, therefore, certain impulses. Thus, it is important that we, as therapists, were attentive to our own associations and memories.

Examples of the therapist’s thoughts and experiences:

- I was in a similar situation;
- It always ends badly;
- The last time I had to explain;
- I was told off at school;
- In such cases, Father was very angry.

Analysis of fantasies and expectations

Communication with our clients is nearly always full of fantasies, fears or expectations. These fantasies can be both pleasant and unpleasant, alluring or intimidating. We may have these as

something to wish for the client or for our self, and sometimes we fear and hope that these would not happen.

The reality, which cannot be observed and understood directly, which was not faced yet in life, one may create. Individual may outline the picture, based on available pieces or shapes. Things that one is able to see in an incomplete picture, it is often determined by ones past experience.

Fig. 8. Area for analysis of fantasies.

In this area, we try to capture and describe the fantasies that arise from the interactions between the therapist and patient. The domain of fantasies can be divided into: expectations, fears and dreams. The fantasies of a therapist might include the fear of aggressive or seductive impulses towards the client, which in turn could both have a negative impact on the therapy in general. Possible questions arise: “What do I fear or expect from the patient?” “What would I like from the patient?”

Examples of the experiences of the therapist:

- He may commit suicide;
- I hope that she will be grateful to me;
- He (or she) can appreciate my professionalism;
- My reputation may become compromised;
- I deserve a little ’something’;
- What if I'm wrong?

Sometimes, we may experience some unpleasant feelings, and wonder, “Why am I so nervous or do not feel safe?” The answer does not always come by itself. Sometimes it takes time to get access to the causes of these experiences. However, the most valuable professional capacity here would be the ability to notice and acknowledge these feelings, to contain them, put them into words, to be later analyzed.

All aspects of the therapist’s experience are important and interconnected. For example, past negative experiences may explain some of the unpleasant emotions or disturbing fantasies. An assessment of what is happening often depends on past experiences, or the absence of any experience. It therefore makes sense to point out, again, that the significantly important themes

have repeated experiences, the ones that we go through regularly or repeatedly while interacting with the client in a therapeutic setting, or in our dreams or fantasies outside the session. In this case, we are in a position of the 'other' people, who regularly interact with the client, and have the opportunity to experience the relationship that the client offers to others, consciously or unconsciously. It therefore makes sense to analyze the countertransference as if you are engaging in a long-term therapeutic relationship.

An example of the analysis of countertransference

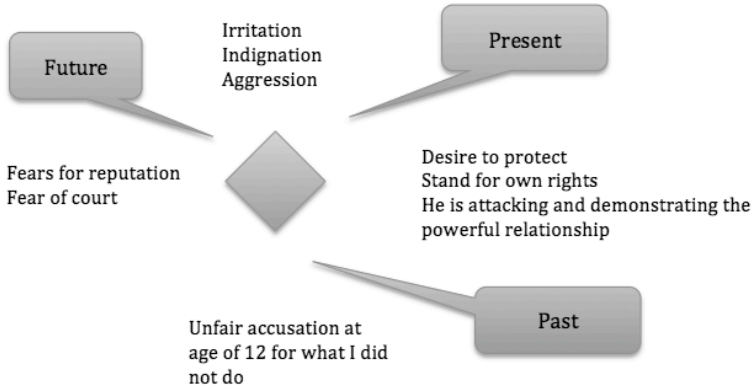


Fig. 9 Example of differentiating experiences of the therapist.

Example for content formulation of countertransference reactions:

- Time and time again, communicating with the patient I feel ...
- Time and time again, communicating with the patient, I want ...
- Time and time again, communicating with patients, I remember ...
- Time and time again, communicating with the patient, I expect ...

The absence of any fixed experience (emotions, impulses, associations or fantasies) in a particular dimension of analysis can also serve as a diagnostic sign, revealing a therapist's "blind spot", or an area for further investigation. The less the client is able to verbalize his/her own experience, the more the therapist must rely on his/her inner experiences, as a kind of representation, or reflection of the patient's experience, through their own countertransference reactions.

Let me give a small, practical example: During the therapy, the patient reported the following: "It seems to me, as always, that I have to figure it all out again, by my self. But it's okay, I'll manage it".

Obviously, such statements from the client contain some disappointment, hidden charges, the need for support, or even despair or fear, because he is afraid not to cope with these issues.

However, nothing about this is properly verbalized. Based on the concept that the unconscious is something that can not be verbalized, this experience is not perceived by the client (transference), and if you would ask (him), he probably would reject these assumptions.

The therapist might feel resentment (emotion); he might want to justify himself (and convince) the patient that he is ready to help him (impulse). The behaviour of the patient seems outrageous. Why? The patient did not say that the therapist is not supportive enough, or does a poor job: but the implication is explicit.

In the therapist's assessments, he may say: "How can you say that? I am trying so hard to help you here! I possibly understand you like nobody else does, and yet you seem to be blaming me for something." Perhaps this emotional reaction (of perturbation) is caused by a previous in the therapist's situation (an association), in which he has already experienced something of this sort of conflict (of fairness or justice), where he had to defend himself. But this 'difficulty' can lead to a loss of distance with the client and to a response that is almost an open accusation from the person, who is not actually presenting in psychotherapy session. In contrast, the ability to notice and acknowledge these feelings by the therapist can possibly turn them into valuable information about the patient (and the therapist) and then these can be used for good.

Here's another example of descriptions of countertransference feelings recounted by Nancy McWilliams (1998) in her famous book on Psychoanalytic Diagnosis:

> *I started, in fact, not even noticing it, to feel tired. Suddenly, I realized that I had not heard anything that he (the patient) spoke for several minutes. At this time, I fantasized how I will represent my work with him as a medical history to some of my distinguished colleagues, and what impressions they will make on my record because of my mastery. When I woke up from this narcissistic thinking and began again to listen to the patient, I was attracted by the fact that he cited in support of his mother, namely, whenever he took part in a school play, the mother sewed him the best costume, again and again rehearsed with each line dialogue. On the day of performances she sat in the front row with whole appearance radiating her pride. In my fantasy I was strikingly similar to the mother of the patient in his childhood, seeing it as a potential opportunity to improve his reputation. Racker would call such countertransference as complementary because my emotional state repeated the important object from the childhood of the patient. If the contrary, I would supposedly feel the same as my patient as being a child - I am basically considered only as a means of enhancing mother's own self-esteem (equiprobable result in an emotional atmosphere which has developed between us) - then my countertransference can be termed as concordant. (McWilliams, 1998).*

If we analyze the description of the proposed model, we get the following picture:

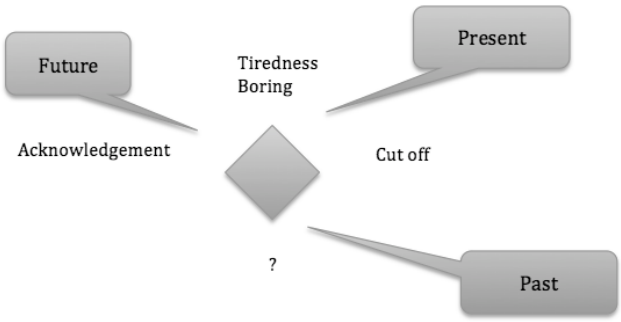


Fig. 10. Differentiation of the therapeutic experience (eg McWilliams).

The content in the field of associations seems to be missing. However, in her assumption McWilliams notes, "*I would supposedly feel the same as my patient as being a child – I am basically considered only as a means of enhancing mother's own self-esteem, then my countertransference may be called as concordant*".

If we tried to go deeper, and would even have a chance to ask McWilliams some questions, we might be lucky to discover what memories and associations came into her mind during this contact with the client.

Besides described operationalization of transference and countertransference, traditionally, these phenomena are divided into either positive and negative. This is a quite conventional division that reflects a portable subjective emotional component of warm and cool spectrum of emotions, in it's content and context, it is essentially associated with love (acceptance or rejection).

Psychotherapist with the patient	**Positive countertransference**	**Negative countertransference**
Time and time again, in communication with the patient, **I feel ...**	Sympathy, tenderness, affection, admiration, interest, calm, relaxation, etc.	Anger, suspicion, resentment, indifference, contempt, disgust, boredom, tension, etc.
Time and time again, in communication with the patient, **I want ...**	To support (them), to get closer, to embrace, to protect, to brag, to instruct and guide, etc.	Disconnect, move away, to blame, to excuses, to compete, to humiliate, to punish, etc.
Time and time again, in communication with the patient, **I remember ...**	Support and care, adoption, protection, rewards, recognition, encouragement, gratitude	Penalty, charge, expose, shame, shame, guilt, humiliation, etc.

Time and time again, in communication with the patient, **I expect ...**	Encouragement and reward, recognition, admiration, invitations, flirting, seduction	Threats, accusations, frustration, punishment, trick, treachery

Table 1: Diagram of Operationalization.

Conclusion

Psychotherapy is not a harmless procedure: It can bring both good and it can do harm. Therefore, the therapist should be extremely competent in matters concerning personal interaction. These can be achieved as a result of special education with a lot of practices and regular supervision. An analysis of the therapist's countertransferential reactions can help the therapist to become more natural, congruent, and authentic in their relationships with their clients, helping the clients to become also more natural in a relationship with themselves, and with others.

Countertransference may serve as a valuable assistant, and it can also assume an insurmountable obstacle in any work with the client, … if the therapist is not aware of his own feelings. This is perhaps one reason why a therapist cannot work equally well with each client. This is what often makes a client 'difficult' to work with. In the therapeutic work, this difficult interaction sometimes can be replaced unconsciously with a variety of less emotional and less painful manipulations: including medication, testing, various techniques, etc.

Irvin Yalom in his famous (1991) novel, "Love's Executioner and Other Tales of Psychotherapy" writes,

> *The world's best tennis players train five hours a day, to address deficiencies in their game. Zen master constantly seeking coolness of thought, the dancer - elegance of movement, and the priest all the time interrogating his conscience. Every profession has areas in which a person can improve. For psychotherapist this area of immense room for improvement, which can never go to the end, in professional language is called countertransference.* (Yalom, 1991)

In order to be an effective therapist, you need to have worked out most of your own problems, and to have developed sufficient capacity for awareness of own emotional reactions. You should be able to distinguish your own past experience from the reactions provoked by the behaviour of the patient. Some of these counter-transferential reactions will be conscious, and can actively and consciously be used in the therapy.

The inability to understand fully your own emotional reactions is a major component for the

incidence of ‘burn-out’ syndrome in therapists. The mental apparatus of the therapist is the only tool for work, so it must be kept in order. The reality that the psychotherapist is experiencing, in contact with client during the time of the session, could be similar to reality that others face within a whole 24-hour period. Only the therapist can find an appropriate way to convey to a client this valuable information, whilst making sure that he is ready to accept it.

In summary, I would like to say that I see the application of this model as being very useful and friendly and not complicated for practical use. This model allows the psychotherapist’s observations and conclusions to operationalize, as well as to help them prepare for supervision.

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