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THE FEAR OF THE UNKNOWN: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF SOMATIC COUNTERTRANSFERENCE EXPERIENCES OF PSYCHOTHERAPISTS

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The Fear of the Unknown: An Interpretative Phenomenological Analysis of Somatic Countertransference Experiences of Psychotherapists

Bilinmeyenden Korkmak: Psikoterapistlerin Somatik Karşıaktarım Deneyimlerinin Yorumlayıcı Fenomenolojik Analizi

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Abstract

Countertransference is considered as an important therapeutic tool especially in psychoanalytic psychotherapy. However, bodily aspect of countertransference, namely, somatic countertransference is often overlooked in both literature and clinical practice. In the present study, it was intended to examine psychotherapists' bodily experiences in countertransference in detail. In line with this objective, data were collected using diaries kept by participants and in-depth interviews. Seven psychoanalytically oriented psychotherapists were included in the study and firstly, they were asked to monitor their bodily experiences in sessions and to keep a diary regularly about such experiences for eight weeks. Once diaries were completed, in-depth interviews were conducted with participants to gain further understanding about their experiences in the process. Data were analyzed using Interpretative Phenomenological Analysis and five main themes emerged: Mind vs. Body, Bringing the Body into the Room, Bodily Experiences, Working with Somatic Countertransference and Getting in Touch. Findings and clinical implications were discussed in relation to existing literature and recommendations were made in terms of further research and clinical practice.

Keywords: somatic countertransference, countertransference, body in psychotherapy, nonverbal communication in psychotherapy, interpretative phenomenological analysis

Özet

Karşıaktarım özellikle psikanalitik psikoterapide önemli bir terapötik araç olarak kabul edilmektedir. Fakat, bedensel deneyimler genellikle karşıaktarımın hem literatürde hem de klinik uygulamada göz ardı edilen bir tarafı olmaktadır. Bu çalışmada, psikoterapistlerin karşıaktarımdaki bedensel deneyimlerinin detaylı bir şekilde incelenmesi amaçlanmıştır. Bu amaç doğrultusunda, terapistler tarafından tutulan günceler ve derinlemesine mülakatlar yardımıyla data toplanmıştır. Çalışmaya psikanalitik yönelimli yedi psikoterapist dahil edilmiştir ve öncelikle sekiz hafta boyunca seanslardaki bedensel deneyimlerini izlemeleri ve bununla ilgili bir günce tutmaları istenmiştir. Güncelerin tamamlanmasının ardından, katılımcıların süreç içindeki deneyimlerinin daha iyi anlaşılması amacıyla derinlemesine mülakatlar yapılmıştır. Data, Yorumlayıcı Fenomenolojik Analiz ile analiz edilmiştir ve beş ana tema ortaya çıkmıştır: Zihin ve Beden Yarışı, Bedeni Odaya Getirmek, Bedensel Deneyimler, Somatik Karşıaktarım ile Çalışmak ve Temas Kurmak. Sonuçlar ile klinik çıkarımlar mevcut literatür doğrultusunda tartışılmıştır ve sonraki araştırmalara ve klinik uygulamalara dair öneriler sunulmuştur.

Anahtar kelimeler: somatik karşıaktarım, karşıaktarım, psikoterapide beden, psikoterapide sözsüz iletişim, yorumlayıcı fenomenolojik analiz

INTRODUCTION

Having emerged as a “talking cure”, the main focus of psychotherapy has conventionally been verbal interaction between therapist and the patient (Freud, 1895/1955, p. 29). This verbal emphasis of psychotherapy dates back to mind-body dualism. Descartes’ idea that mind “is entirely and absolutely distinct from my body and can exist without it” shaped our understanding of mind-body relationship to great extent (as cited in Wilkinson, 2000, p. 168). Although Freud defined ego as “first and foremost a body ego” reflections of mind-body dualism can be observed in psychoanalysis as well (Freud, 1923/1955, p. 3962) Treating mind and body as separate entities leads body to be left out of therapy room. Moreover, even though countertransference is regarded as an important therapeutic tool in psychotherapy and utilized as a part of psychotherapeutic practice, bodily aspect of it seems to be splitted off and again left out of therapy room.

Miller (2000) drew attention to such absent body in therapy room and proposed that there is a fear related to body in psychoanalytic community even for those who are bodily oriented therapists. Yet, it is believed that verbal exchange between patient and therapist is only a small part of the whole interaction between them (Pally, 2001). Moreover, affective interaction between therapeutic dyad is considered to be mostly nonverbal (Schore, 2014). In the light of such information, scarcity of bodily aspect of countertransference in literature is striking, especially as even the wording of “somatic countertransference is equivalent to saying swimming fish” (Soth, 2002, p. 131). Hence it is believed that body, beginning with therapists’ very own body, should be attended in psychotherapeutic encounter and integrated in practice. For this

purpose, firstly therapists' bodily experiences in psychotherapeutic encounter should be investigated and discussed in relation to relevant literature.

1.1 CENTRAL THEORETICAL CONCEPTS

1.1.1 Countertransference

In the earlier years of psychoanalysis, concept of countertransference was considered more as an obstacle in the course of psychotherapy rather than a significant tool to be utilized. Freud pointed out a new concept "'counter-transference', which arises in him [in therapist] as a result of the patient's influence on his unconscious feelings" (Freud, 1910/1955, p. 2310) Although it can be concluded that he acknowledged subjective being of psychotherapist and existence of countertransference feelings, it was strongly suggested that therapists should preserve their blank, objective interpreter roles and leave their own subjectivity out of the room. From such point of view, countertransference feelings should be acknowledged only to be able to eliminate them as an obstacle in psychotherapy.

Reflecting on Freud's perspective on countertransference, Heimann (1950) defined countertransference as "all the feelings which the analyst experiences toward his patient" and she further proposed that "countertransference is an instrument of research into the patient's unconscious" (p. 81). This contribution can be considered as the first important shift in perception of countertransference. Yet, despite acknowledgement of countertransference as an important instrument in psychotherapy, therapist's subjective being in the room still were far from to be discussed. Similarly, Racker (1968) indicated that

countertransference is “the greatest danger and at the same time an important tool for understanding” (p. 127). Even though it was acknowledged as a therapeutical tool on the one hand, countertransference was still regarded as an obstacle in therapy on the other hand. Winnicott (1949), in this sense, indicated that therapists would maintain their objective stance even if negative feelings were provoked in them.

Sandler (1976) on the other hand, underscored intersubjective aspect of countertransference with the concept of “role responsiveness” and referred to therapeutic relationship as an area in which the patient and the therapist both influence and are influenced by each other (p. 45). Furthermore, recognition of therapists’ subjectivity became much more prominent with the rise of relational psychoanalysis. Therapist’s being an objective observer in the relationship was considered as impossible; and countertransference notion was refined in terms of intersubjective therapeutical play in which both parties actively participated (Mitchell, 1988; Renik, 1993). Thus, the sphere of countertransference expanded with inclusion of therapist’s subjectivity in the room. Yet, despite a prominent shift towards expansion of perspective on countertransference, attention to bodily aspect of countertransference is still far from abundant.

1.1.2 Projective Identification

Projective identification is another important concept regarding somatic countertransference. The concept of projective identification was introduced by Klein (1946) in connection with the paranoid-schizoid position referring to the projection of splitted aspects of the self to the other. According to her, infants’ psyche has two main intincts, which are libido and aggression and they struggle

with these different aspects of psyche; one is striving to survive and the other one is bringing annihilation. Thus, in order to protect libidinal intincts from the aggressive instincts, these aspects of psyche are splitted apart. Then, these splitted parts of ego are projected to the mother, to her breast, and thus; her breast is now perceived by the baby as good or bad reflecting the good and bad aspects of the self. Feeding sequences are also experienced accordingly. When they are fed, they experience the breast as a good and nurturing one which will keep them alive. However, in the face of hunger when breast is not there yet to nurture, this is experienced as if breast is all bad, withholding and punishing one. She further explained the process as "Much of the hatred against parts of the self is now directed towards the mother. This leads to a particular form of identification which establishes the prototype of an aggressive object-relation." (Klein, 1975, p. 8). Those unintegrated parts of psyche are now experienced as if they belong to that object, but again good breast and bad breast are not experienced as if they belong to the same mother. They are still unintegrated since the former should be protected by the latter. Moreover, they are also full of anxiety and terror of annihilation which is mainly experienced as a fear in relation to "an uncontrollable overpowering object" (Klein, 1975, p. 4). Thus, by splitting and projecting those unintegrated parts of psyche, infants not only control the object, the mother; as there is not a clear distinction between them at that developmental phase, but they also store unintegrated parts of their ego in that object. Thus, in a way they keep such unitegrated parts alive in a container. However, it should be noted that baby splits unaccepted parts of self and projects those parts to object; to mother in this way unwanted aspects of the psyche are Thus, the concept from Klein's perspective refers to more of an intrapsychic process; it occurs in phantasy of baby.

On the other hand, moving from one-person psychology to two-person psychology, projective identification became to be depicted as if someone or

something penetrating the other. Accordingly, Rosenfeld (1952) explained his observations of the patient's "phantasies of going into" him, "being inside" him; and he also noted his feelings of "the projection of the internal object (the super-ego) into" him (p. 121). Money-Kyrle (1956) described his experience in a similar manner and compared projective identification to "being robbed of my wits by him" (p. 352). Reflecting on the concept, Ogden (1992) from a contemporary perspective claimed that "projective identification does not exist where there is no interaction between projector and recipient" (p. 14). Thus, Klein's (1946) idea of the baby splitting and projecting unacceptable parts of its self into mother and perceiving mother as if those unwanted parts belong to her was further elaborated and perspective of the recipient of projected material was included in understanding of concept as well. Namely, the concept of projective identification began to move from being an intrapsychic concept to more intersubjective process. This intersubjective understanding of projective identification owes much to Bion's (1959) contribution to definition of the phenomenon with an emphasis of communication and the role of the mother as a part of the process.

1.1.3 Containment

Elaborating on Klein's (1946) understanding of notion, Bion (1959) focused on intersubjective aspect of projective identification and underscored its function as a "method of communication" (p. 310). He pointed out the normal degree of projective identification in relation to introjective identification which is core of normal development as claimed by Bion (1959). According to him, the reason behind projecting some parts of the psyche was that they were too intense to be contained by the self, in other words, they were the fear that "the child

could not contain" and thus they were projected into the object for the object could transform those parts so that they could be taken in again (1959, p. 313). He explained his experience with a patient in clinical practice as the patient split his fears of death which were too intense for his psyche to be contained and thus put them into therapist, according to him "the idea apparently being that if they were allowed to repose there long enough they would undergo modification by my psyche and could then be safely reintrojected" (p. 312).

Unlike Klein (1946) who conceptualized projective identification as an aggressive defense which is associated to paranoid schizoid position, Bion emphasized the role of projective identification as way of communication with the object in normal development. This shift in conceptualization of projective identification made room for mother in the process as well. As stated by Bion (1959), projective identification enables patients to investigate their intolerable feelings "in a personality powerful enough to contain them" (p. 314). In other words, the baby needs mother's containing and metabolizing function. With the help of a such more powerful psyche, baby can develop such ability of metabolizaton for itself. Mother, or psychotherapist in clinical practice, becomes a container for unbearable feelings, a container which transform such feelings in his/her own psyche and make them tolerable enough to be eventually reintrojected by the baby, or patient. This function of mother was referred as alpha function in which she transforms beta elements (β-element) into tolerable ones (Bion, 1962, p. 2). Bion explained this alpha-beta process:

> In the situation where the β-element, say the fear that it is dying, is projected by the infant and received by the container in such a way that it is "detoxicated", that is, modified by the container so that the infant may take it back into its own personality in a tolerable form. The operation is

analogous to that performed by α-function. The infant depends on the Mother to act as its α-function (Bion, 1963, p. 27).

In other words, whole process can be explained with a contained and container relationship. Baby who is contained puts its intolerable toxic material into the mother and the mother as a container metabolizes and transform this material to a form that makes it possible for the baby to introject and be able to contain. Reflecting Bion's (1962) ideas about alpha elements, Ogden (1979) explained that there are three phases of projective identification: initially unconsciously getting rid of a part of the self by putting into the other; second, exerting pressure to make the recipient have those feelings, and lastly, reinternalizing the modified version of projected material. The patients put the unwanted aspect of themselves to the therapist and with an interpersonal interaction enable the therapist to experience those feelings, then reintrojects this new material which is transformed by the therapist maybe into a less harmful one. Hence, especially regarding the aspects that Ogden (1979) detailed, it can be inferred that the therapists take in the projected “bad” part of the patient, influenced by it and feel it, act upon it, thus, presenting the new transformed form of it and the patients take this back into their psyche. Analytic relationship involves two separate subjectivities who have an impact on each other and they build a new “one” construct together or in other words: “analytic third” (Ogden, 1994, p. 4).

1.1.4 The Analytic Third

Reflecting on Green's (1975) 'analytic object', and Winnicott’s (1960) statement that “There is no such thing as an infant" [apart from the maternal

provision]"; Ogden (1994) defined analytic third as "a product of a unique dialectic generated by (between) the separate subjectivities of analyst and analysand within the analytic setting" (p. 4). According to him, it was not possible consider therapist and patient as separate entities being apart from the relationship with each other (Ogden, 1994). Moreover, for him, therapeutic encounter referred to an interaction of therapist, patient and the analytic third (Ogden, 1994).

Ogden later elaborated on projective identification in association with analytic third (Ogden, 2004). According to him, projective identification can be considered as the recipients making room in their psyche so that projectors can experience what they cannot experience themselves. He further emphasized the function of analytic third as "a vehicle through which thoughts may be thought, feelings may be felt, sensations may be experienced, which to that point had existed only as potential experiences for each of the individuals participating" (Ogden, 2004, p. 189). Thus, highlighting the roles of both participants he acknowledged that both projector and the recipient involve in projective identification, it is an interaction of subjectivities which produce, as a result, "a third subject, "the subject of projective identification," that is both and neither projector and recipient" (Ogden, 2004, p. 188). He also defined analytic third in terms of projective identification as "subjugating third" (Ogden, 2004). For the purpose of projective identification, participants let themselves to co-created intersubjective third for a moment without the limits of who they were at such point (Ogden, 2004).

1.1.5 Nonverbal Aspects of Interpersonal Communication

Intersubjectivity and communication between subjectivities are considered to be mainly body based phenomena. Accordingly, echoing Freud's depiction of ego, Gallese (2009) referred to intersubjectivity as "first and foremost intercorporeity" (p. 523). Merleau-Ponty (1964) stated that "I live in the facial expressions of the other" (p. 146). Reflecting on Merleau-Ponty's (1964) ideas, Diamond (2001) pointed out that we all exist in an intersubjective context, namely, in relation to the other and the environment; and that relation is primarily body based. Therefore, all bodily sensations, as maintained by Diamond (2001) refers to communications and manifestations of relatedness to the others. Furthermore, Orbach (2003) put "…no such thing as a body, there is only a body in relationship with another body" (p. 11).

Also, it is impossible to exclude bodily aspects of intersubjective relating and communication in psychotherapy. As Balint (1949) pointed out body is at the core of "psychoanalytic situation which is essentially two body situation" (p. 222). Regarding this communicating aspect of body in therapeutic encounter, Bollas (1987) coined the term "the unthought known" and explained nonverbal intersubjective communication as "we somatically register our sense of a person: we 'carry' their effect on our psyche-soma and this constitutes a form of somatic knowledge which again is not thought" (p. 282). Diamond also highlighted the function of body as a medium of communicating feelings and noted that in psychotherapy, therapists might pick up their patients' emotional pain via bodily communication and experience such feeling as a physical sensation (2001). On the other hand, somatic countertransference is also considered as a form of preverbal communication between mother and infant but occurs as a result when there was a bad fit in terms of Daniel Stern's concept of "vitality affects"

(Wiener, 1994). Besides, Wiener (1994) claimed that this early failure in communication with caretaker also results in psychosomatic problems which cannot be expressed verbally. However, Pally (2001) stated that verbalizing nonverbal behaviors and understanding unconscious meanings might be useful, however, it should be born in mind that "people are designed by nature to interact nonverbally at all times" (p. 91). Pally (2001) emphasized that nonverbal experiences can emerge in psychotherapy not as a result of regression or defenses but as a result of a basic, normal human interaction. We are innately designed to communicate in nonverbal means.

Moreover, it is thought that language alone is not enough to capture and convey intersubjective experience. Stern (1985) pointed out that "language is inadequate to task of communicating" (p. 178). According to Stern (1985), at first infants' knowledge on intersubjective experience is based on nonverbal behaviors and not shareable, with development of language they can finally share their experiences however, on the other hand, he further maintained that "language forces a space between interpersonal experience as lived and as represented" (p. 182). Pally (2001) also further underlined that there is a gap between verbal expression and feelings, between "the verbalizable self and the experiencing self" (p. 73). It seems as if one might miss some aspects of lived experience in the process of translation into verbalized experience.

1.1.5.1 Attunement

As mentioned before, initial experience in terms of communication begin with communication with caretaker. Ferrari (2004) stated that functioning of mind begins with its initial sensory experience. Beebe and Lachman (2002) further described how baby and mother imitate each other's facial expressions,

and suggested that “these “matching” experiences contribute to feeling known, attuned to, on the same wave length. Each partner affects the other so as to match affective direction, and this matching provides each with a behavioral basis for entering into the other’s feeling state” (p. 98).

Stern (1985) identified three core steps of intersubjective exchange of affect. Firstly mother needs to be able to read baby’s behavior and she should be able to correspond to that behavior rather than imitating it and then baby should be able to read that respond of mother. He defined “affect attunement” as behaviors that reflect a shared affective experience without simply imitating behavior related to that inner experience (Stern, 1985, p. 142). Also, he stated that “most attunements occurred across sensory modes” (Stern, 1985, p. 148). Main aspects of attunement were identified through sensory states. For instance, he exemplified attunement between a mother and roughly eight-month-old boy as a match between the boy’s physical effort with his arms and fingers while tensing his body, and mother’s vocal-respiratory effort that accompanies the boy’s behavior in terms of intensity and rhythm. He further explained that such rhythm “can be delivered in or abstracted from sight, audition, smell, touch, or taste” (Stern, 1985, p. 152). Moreover, Ogden, Minton and Pain (2006) also emphasized the importance of mother’s “reciprocal, attuned somatic and verbal communication with her infant” for basis of secure attachment (p. 43). Thus, attunement in terms of bodily communication taking place between infant and caretaker is regarded as a significant factor in terms of development.

1.1.5.2 The Contribution of Neuroscience

Neuroscience offers several important evidences for nonverbal aspects of communication as well. Mirror neurons now are regarded as one of those

significant components of nonverbal communication as well. It was established that "in humans, there is a kind of direct resonance between the observation and execution of actions, and the possible relation to monkey mirror neurons" (Meltzoff & Decety, 2003, p. 493). Hence, it is believed that observing an action of the other leads to the same experience as if individuals experience such action themselves. The neuron activity related to an observed behavior is considered as a direct manifestation of such observed behavior in brain of observer (Rizzolatti, Fogassi, & Gallese, 2006). The idea of mirror neurons refers in a sense experiencing the other's experience. Moreover, this experience does not imply a mere imitation but also grasping the whole experience with its affective states as well. In this regard, Gallese, Eagle & Migone (2007) indicated that people can understand each other's affective state via internal somatosensory simulations. They further remarked that "the other's emotion is constituted, experienced, and therefore directly understood by means of an embodied simulation producing a shared body state" (Gallese, Eagle & Migone, 2007, p. 143). Thus, it seems that through such experiential communication people are able to grasp the others' experience in a way that seems as though people met in a body so that they can understand the whole experience of the other.

Additionally, right brain activity in psychotherapy is also another important aspect of nonverbal communication. While left brain enables communication of conscious states via language; right brain serves to communicate unconscious states and particularly it enables communicating the unconscious affective experience (Schore, 2007). Thus, Schore (2001, 2007) proposed that psychotherapeutic communication primarily is a communication between right brains of patient and therapist. Similarly, Meissner (2007) also underscored the activity of right brain in contrast to left brain activity which is dominant in practice and associated with verbal, interpretative work. Furthermore, it is believed that right hemisphere is strongly related to the

unconscious memories to be worked through in psychoanalytic treatment (Gainotti, 2006). Schore (2014) also emphasized the right hemisphere interaction in psychotherapy and noted that nonverbal communication can convey an embodied form of unconscious affective relational information about patient as well as therapist. Thus, it can be concluded that in therapeutic work, it is the right brain activity that enables working with affective and unconscious experiences when compared to conventional emphasis of verbal, left brain activity.

1.2 SOMATIC COUNTERTRANSFERENCE

1.2.1 Definition of Somatic Countertransference

Somatic countertransference, in a broad sense, can be considered as bodily experiences of psychotherapists in therapeutic process. It is believed that therapists attending to their own bodily experiences in countertransference may provide important cues regarding patients' inner life and the therapeutic relationship in the room (Pally, 1998; Wiener, 1994). Bloom coined "embodied attentiveness" and emphasized that therapists' sensation can provide a deeper connection in therapy as well as a deeper understanding of therapeutic relationship (2006, p. 65). Furthermore, Lombardi highlighted becoming aware of bodily experiences and working with them to "reach a first authentic form of subjective existence" (2011, p. 6). According to Fries, "the analyst's willingness and capacity to attend to her somatically encoded countertransference can provide a crucial level of knowing and relating" (2012, p. 588). Therapists' attending and working with their bodily experiences in countertransference not

only enables grasping communicated material of the patients but it also makes patients feel heard and understood (Divino & Moore, 2010). Moreover, therapists' attending to their own body is regarded as providing a space for patients to experience what is unbearable for them or in other words what they cannot experience otherwise. Accordingly, Greene (2001) indicated that therapists' attending to their bodily sensations in sessions is crucial in terms of providing "a secure psychic container" to patients (p. 571). As the therapists offer and share their body with their patients, it would be possible for patients to have a lived body their own (Orbach, 2006). Thus, in a sense, it can be inferred that attending to body in sessions offering a body for patients to bear the unbearable.

Additionally, in line with previously discussed theoretical concepts, perspectives on somatic countertransference can be divided into two categories: the effect of patient on psychotherapist and the therapists' bodily experience in the intersubjective dialogue. Namely, the former refers to therapist as an objective recipient of patient's projected unconscious material, whereas the latter implies two interacting subjectivities in the room. Orbach and Carroll (2006) emphasized this intersubjective aspect of somatic countertransference and defined somatic countertransference as "the therapist's awareness of their own body, of sensations, images, impulses, and feelings that offer a link to the patient's process and the intersubjective field" (p. 64). Similarly, Sletvold (2015) referred to such phenomena as "embodied empathy and intersubjectivity" (p. 83). According to Aron (1998), during psychotherapy process patient and therapist shares "a psychoanalytic skin ego" (p. 25). He maintained that they both affect and been affected by each other and this resembled "each is breathed in and absorbed by the other" (p. 26). Dosamantes-Beaudry (1997) proposed that intersubjective aspect of somatic countertransference regarding therapeutic relationship could be best described by the concept of "somatic intersubjective

dialog" however for describing the experiences of merely one member of dyad "somatic transference" and "somatic countertransference" would be appropriate (p. 522). On the other hand, others described somatic countertransference as the impact of patient and patients' material on the therapist (Forester, 2007; Martini, 2016; Samuels, 1985). It seems that there is a debate in literature regarding who owns these sensations; is it therapists or patients, or something co-created in between?

1.2.2 Therapist and Patient Factors

It is remarkable that most of the work in literature focus on the origin of sensations. The main question that literature aim to address seems to be the question of how these sensations emerge and if there is any patient or therapist related factors (Field, 1989; Fries, 2012; Jacobs, 1973). Jacobs (1973) underscored therapists' repeated exposure to traumatic bodily experiences of patient lead them to become aware of their bodily sensations in sessions. He further noted that therapists' own bodily history and moreover similarity between patients' history therapists' history are other factors that bring about somatic countertransference. Stone (2006) identified patient and therapist related factors and claimed that particular typology of therapist in other words, those who have introverted intuition in Jungian terms are more likely to have somatic countertransference experiences.

On the other hand, according to him, patients who are defined as in borderline and psychotic level of development are more likely to induce such sensations in therapist (Stone, 2006). Samuels (1985) also stated that somatic countertransference as a communication from patient and therapist's psyche

becomes a “via regia” into the patient’s psyche (p. 51). Moreover, he proposed that patients with instinctual problems more likely to elicit somatic countertransference in therapists (Samuels, 1985). Similarly, reflecting on Bromberg’s (2001) idea that patients with eating disorders utilize dissociation to regulate their desires, Gubb (2014) concluded that her intense hunger while working with eating disorder can be some sort of dissociation led by projective identification. For her, focusing on her own desire of food instead of patient’s in that case was a further cue for patient’s dissociation.

Traumatic history of the patient was also associated with somatic countertransference. Especially Van der Kolk’s (1994) statement that “the body keeps the score” has reflections in the literature. Such traumatic experiences which are encoded in body are expressed nonverbally in the therapeutic encounter. In that sense, Forester (2007) remarked that patients’ dissociated body experience would affect therapists’ body experience as well. Schore (2014) also claimed that such nonverbal communications through transference and countertransference are representations of therapeutically expressed forms of dissociated affective experience that is related to an early relational trauma. A disruption in baby and caretaker relationship, mostly due to physically or emotionally unavailable caretakers, is also regarded as among factors that increases likelihood of somatic countertransference (Ross, 2000). Rumble (2010) emphasized patients’ history of early relational trauma as a precursor to somatic countertransference. Similarly, Martini (2016) discussed communication aspect of somatic countertransference in the patients’ part and regarded the phenomenon as an archaic defense of patient which signals an early damage in psyche.

Yet, although Pally remarked that somatic countertransference might be evoked by the patient, but it should be considered as a normal human

communication rather than a defensive or regressive act (Pally, 2001). Field (1989) also highlighted the intersubjective co-created aspect of somatic countertransference and remarked that it might not be possible to determine what belongs to whom. He pointed out that it occurs more of a somewhere in between rather than belonging merely one part of the therapeutic dyad. In a similar manner, Zoppi (2017) argued against the idea of passive therapist who is merely affected by patients' material without any contribution rather she considered therapeutic encounter with bodily experiences as a shared experience. Orbach (2006) described how intertwined the bodily experiences are in therapy room by referring to intersubjective aspect of body and asserted:

> No less than our strictly psychological capacities-if I may separate them out for the moment-our bodies form part of the intersubjective relating in the room. Our body is part of the patient's bodily experience, and our personal experience, and our personal experience of our own body is affected by our sense of the patient's body and what we pick up as his or her sense of our body (p. 96).

Additionally, Fries (2012) depicted her bodily experience in session "a meeting of unconscious longings, mutually unrealized in both his early life and my own" (p. 597).

According to Slavin and Rahmani, rushing in putting bodily experiences in sessions to categories such as projective identification or countertransference "often represents a defensive flight from experiencing the simple power of a relationship that the therapist needs to experience" (2016, p. 164). Reflecting on Benjamin's (2004) concept of thirdness which simply refers to a reciprocal and mutually influencing interaction, Slavin and Rahmani proposed that "there is no doer and no done to" in terms of bodily experiences in therapeutic encounter (p. 164). Similarly, Rappoport (2012) discussed the third in terms of somatic

countertransference and coined the term “somatic third” which she defined as “the space of physical resonance and interactive sensory regulation” (p. 384). She further maintained that “in the space of the “somatic third,” self and interactive regulation takes place and forms, shapes and transforms, newly developing embodied subjectivities (Rappoport, 2012, p. 386).

1.2.3 Bodily Awareness

One of the most important factors regarding clinical utilization of body is perhaps therapists’ relation to their own body. Therapists’ bodily awareness is regarded as “an essential key for monitoring somatic countertransference” (Forester, 2007, p. 73). Accordingly, Shaw (2003) emphasized becoming more “bodily literate” (p. 1). Greene (2001) also explained her method of utilizing “body as an organ of perception”, in which she not only read the body posture of patient but also her own subjective awareness of bodily cues to discover patient’s experience (p. 577). She also underscored intensive training to improve “one’s somatic radar (embodied intuition)” (p. 577). Vulcan (2009) proposed that therapists’ level of body awareness is a significant determinant of discerning somatic countertransference and make sense of it. Bloom (2006) also remarked that the more therapists are connected with their bodies and aware of its expressions the more they can consciously take in and understand patient’s feelings instead of simply reacting to such feeling. Soth (2002) indicated, in a similar manner, that therapists should be “rooted in a continuous awareness of their own somatic reality in the first place” in order to improve their awareness related to somatic countertransference (p. 130).

Developing somatic awareness is regarded as equivalent to obtaining new tools in psychotherapeutic work. According to Miller (2000), as therapists

become more familiar with their bodily experiences they develop more tools for management of somatic countertransference such as grounding, breathing techniques or containing and analyzing such sensations. Forester (2007) also emphasized somatic awareness in trauma work and she indicated that somatic countertransference and awareness regarding such experience are essential sources of information in psychotherapy, especially while working with dissociative patients. According to her, bodily cues when attended, not only provide insight about the relationship and psychotherapeutic process but they also decrease the likelihood of vicarious traumatization. Orbach (2003) also urged therapists to listen, look and feel their own bodies in order to capture its offerings not only in practice but also in personal level. Similarly, Miller (2000) recommended therapists engaging in bodily activities such as exercise, a sport or massage to overcome fear of body in therapy room.

1.2.4 Therapists' Bodily Experiences

Although research on somatic countertransference is scarce in literature, the corporeal experiences of psychotherapists in session are often reported and discussed. It is beyond the scope of this research project to systematically review all reported somatic countertransference experience in literature. However, it is aimed to provide some examples from the literature. Yet, it should be born in mind that somatic countertransference experiences are unique and various; and only a little part of such literature could be mentioned in the present section.

Sleepiness is one of the very common sensations reported by psychotherapists (Field, 1989; Ogden, 2001). Field (1989) concluded that sleepiness might occur when there is an effort to hinder working with a topic

which sensitive or considered as taboo especially when it comes to aggressive or erotic transference. On the other hand, he also noted that such sleepiness might be a reflection of "shared intimacy of `sleeping together' provided a mother-baby rapport" which was probably absent in patient's history according to him (Field, 1989, p. 515). Field (1989) indicated that he even asked a patient with whom he felt constantly sleepy to find another therapist since he had hard time to stay awake and thus thinking that he could not help the patient, however he stated that they continued to work upon the patient's request and therapy led to natural termination. According to him, what was beneficial to that patient was to be "endured" by someone (p. 514). Echoing Winnicott's (1971) ideas, Orbach (2003) also proposed that patients need an object to destroy in analytical play and therapists in return need to survive such attempt of destruction.

Sensations in the stomach is also very common phenomenon (King, 2011; Lombardi, 2011; Orbach, 2004). King (2011) described her uneasy sensation in stomach with a patient whom she thought of being stuck with. According to Orbach (2004) physical discomfort related to stomach often refers to a "difficulty in taking in and using what the emotional environment (the mother, the object) has to offer" thus she maintained that therapists' sensations in stomach such as pain, diarrhoea might be a manifestation of the fact that patient trying to evacuate something that cannot be used (p. 142). Lombardi (2011) concluded that his sensation in stomach is a result communication between two bodies in the room which occurred through his "sensory echoing" (p. 9). Martini (2016) reported feelings of nausea with a patient from the very first encounter. He regarded this sensation as a reflection of unintegrated emotional experience which communicated to therapist through projective identification. Reflecting on Da Silva's (1990) ideas, King (2011) emphasized how tummy rumblings of both patient and therapist refer to such a fantasy of being fed by therapist.

Similarly, hunger was commonly experienced by therapists (Greene, 2001; Gubb, 2014; Ross, 2000). Greene (2001) pointed out that her hunger in a session often represented a deprived aspect of patient rather than therapist's being simply hungry. Gubb (2014) noted that she experienced severe hunger, had stomach rumblings and cravings for pizza even usually accompanied by imagery of floating pizza with a patient with anorexia. Gubb (2014) interpreted this experience as her identification with the patient's projection of her dissociated part which craves for food. Ross (2000) reported sudden hunger pang and palpitation in a session in which the patient told her that she wanted to leave therapy; and Ross interpreted this experience as the patient's effort to communicate her intense feelings in the face of separation to therapist. In a session, Dosamantes-Beaudry (1997) felt an intense sensation in her left breast and it was such an intense experience that she could not help reacting the pain with an exclamation of ouch, and patient just then revealed that she was picturing the therapist as a breast and herself as a baby sucking on that breast. Correspondingly, the therapist described her countertransference feelings as if being drained by an infant with such an intense greed and aggression.

Somatic experiences related to breathing seem to be another common sensation in relevant literature as well (Aron, 1998; Greene, 2001; Rappoport, 2012; Stone, 2006). Aron (1998) proposed that we experience most of the psychic material of the patients with our body, especially breath is an important tool. Greene (2001) also articulated her experience of tightness in her whole body, it was so intense that she had difficulty in breathing; yet, according to her, these sensations were building stones of a safe container. Stone (2006) explained an intense moment with a patient in a session with whom he had tightness in his chest and had hard time to breathe. The experience was so intense, he maintained, that he finally asked patient about how his chest feels and patient suddenly took a foetal position and started to cry. There was no verbal exchange

after in that moment, as Stone described (2006). He noticed that his sensation disappeared and he began to breathe normally as the patient cried (Stone, 2006).

With another patient, Stone reported severe pains in his whole body as if patient was attacking him as a response to feeling of being abandoned, he maintained that the "she had literally become a pain in the arse" echoing the patient's history (2006, p. 117). This sensation also had reflections on him related to his own history as a therapist. He indicated how he made sense of such experience reflecting on his own history of childhood as a therapist in a similar context as patient's as well as patient's own history (Stone, 2006).

Some therapists feel their body as shrinking in size, they feel so tiny that they compare themselves Alice's situation in wonderland (Orbach, 2003; Zoppi, 2017). Plus, Orbach (2006) explained how she felt as if her skin was burning and then the story of patient's baby brother who was burned to death was revealed in the next session. In another account, Orbach (2004) explained how one of her supervisees had to interrupt a session due to smell of fire while the patient was telling his story which involves fire but not yet articulated that aspect.

1.2.5 Somatic Countertransference Research

Although many psychotherapists reported bodily sensations in their sessions, research studies conducted about bodily aspect of countertransference are scarce. Among several studies, Samuels (1985) conducted a research project on countertransference in which he also elaborated the term embodied countertransference and concluded that therapist's body can become an important medium in terms of communication between therapeutic dyad. In this project, it was reported that bodily countertransference such as an odd sensation

in abdomen, sleepiness, pain, and sexual arousal was among the most mentioned types of countertransference. Shaw (2004) conducted in-depth interviews and discussion groups with psychotherapists and he proposed that bodily perception of therapists in therapeutic encounter is essential so as to monitor psychotherapy process. His main themes were physical reactions, communication and styles and techniques. Additionally, King (2011) conducted in depth interviews to investigate a specific type of bodily experience in sessions: stomach rumblings. A grounded theory approach revealed four themes; being open, deciding on significance, making meaning, reflecting on practice (King, 2011). Another study conducted by Athanasiadou and Halewood (2011) also examined in-depth interviews with psychotherapists to understand their experience with bodily sensations in sessions, and the findings concur with those of Shaw (2004); therapists' body becomes an important tool to get a glimpse of patient's experience and it is worth to explore those sensations for possible meanings. Moreover, they discussed in relation to their main findings that body as a neglected tool in psychotherapy; their main themes as a result of grounded theory were defending against the experience, recognising lack of somatic insight, developing somatic awareness, owning somatic experience, reflecting intellectually, working with somatic countertransference. However, echoing Freudian understanding of countertransference, they also claimed that somatic countertransference might occur as a result of therapist's transference to the patient and in that case somatic countertransference can also be an obstacle in the course psychotherapy (Athanasiadou & Halewood, 2011).

Similarly, in their quantitative study Egan and Carr (2008) investigated the frequency of several bodily sensations among female trauma therapists with a questionnaire that they adapted from Briere's (1995) Trauma Symptom Inventory. In that study, it was emphasized somatic countertransference was a common experience among female trauma therapists and the most common ones

were sleepiness and muscle tension. Egan, Booth and Trimble (2010) elaborated on Egan and Carr's (2008) study and conducted a similar research with a more diverse group of clinical psychologists and investigated the relationship between somatic countertransference and variables regarding therapist's personal and professional background. The results regarding frequency of bodily experience was in line with Egan and Carr (2008) and sleepiness and muscle tension was the most frequently reported sensations. Yet, no evidence regarding therapists' personal and professional variable was found in the study. In both studies, somatic countertransference was described as an undesirable experience that therapists should monitor and investigate the possible explanations only in order to eliminate, and considered even as a form of vicarious traumatization. However, the present study dissents from such idea and intends to understand and enhance the knowledge of therapists' experience regarding monitoring and utilization of bodily sensations as an intersubjective experience in therapeutic process.

1.3 OBJECTIVES OF PRESENT STUDY

As mentioned before, while countertransference is now considered and utilized as an important tool to understand the patient's psychodynamics in psychotherapy and primarily in psychoanalytic psychotherapy; the information on how psychotherapists experience patient's material not only in terms of feelings but also in their body is limited. However, despite the conventional emphasis on language in psychoanalytic treatment, it is clear that verbal interaction alone cannot convey the whole experience of an individual since in any interaction there is a lot more beneath the words (Pally, 2001).

Moreover, research studies on somatic countertransference in existing literature are not only limited but also mainly retrospective and no study capturing the immediate bodily experience of therapists could be found in the relevant literature at the time. Yet, it is assumed that one should be able to record immediate sensations in order to be able to understand such phenomenon since bodily sensations appears and then disappears momentarily.

Hence, this study intends to contribute to an understudied subject in the psychotherapy literature and highlight possible implications in terms of psychotherapeutic techniques. It was aimed to examine psychotherapists' experiences of attending to their bodies in therapeutic encounter by utilizing diaries kept by psychotherapists regarding bodily experiences in the process; and in-depth interviews which aim to gain further insight their experiences of attending to body in therapy. It was designed as an exploratory study in order to achieve an in-depth understanding and insight on therapists' experiences of somatic countertransference phenomenon. In doing so, it is anticipated to understand therapists' bodily sensations in therapeutic encounter, how they experience these sensations and; if and how they make use of these sensations and to investigate possible connection with these sensations and therapist's experience of therapeutic process.

METHOD

Interpretative Phenomenological Analysis (IPA) was preferred in order to understand therapists' subjective experiences regarding attending to body in therapeutic process and their bodily sensations in the process and how they make sense of such experiences. IPA was appropriate for the present research since it enables detailed investigation of individuals' lived experiences regarding a phenomenon (Smith, Flowers, & Larkin, 2009). Moreover, IPA emphasizes embodied aspect of subjective meaning making of the world and intersubjective processes (Smith et al., 2009). The focus of this research is on the notion of clinical attention to body and bodily sensations of therapists in an intersubjective context of therapeutic encounter; for each unique therapeutic dyad. Hence, IPA approach was relevant due to the topic and the nature of this research project since it provides a detailed examination and understanding of unique meaning making processes regarding embodied experience of the intersubjective world.

2.1 The Primary Investigator

I am a woman in Istanbul Bilgi University Clinical Psychology graduate program adult track. My curiosity about the subject comes from my own bodily experiences in therapy room and of peer-therapists as well as in social relations. I think our bodies are significant tools for basic human interaction and provide an opportunity for us to understand what is beyond words. Thus, I sought to gain in depth understanding about therapists' bodily experiences in psychotherapy and their subjective meaning making. I hope this study contributes, even a little

bit, to provide a space for our bodies in our psychotherapy practice as well as psychotherapy literature.

2.2 Participants

Participants were seven Turkey-based psychoanalytically oriented psychotherapists working in private practice. They were expected to have minimum of three years of psychotherapy experience, trainee psychotherapists were excluded in this study to ensure that participants have enough psychotherapy experience to track their bodily sensations in a session. Participants were recruited by using purposive, snowball sampling. A homogeneous sample was preferred and as they already attend to countertransference as a therapeutical tool, only psychoanalytically oriented therapists "for whom the research question will be meaningful" were included in the study (Smith et al., 2009, p. 49). Due to idiographic approach of the chosen data analysis method, typically a sample of three to six participants were considered appropriate for a master level project (Smith et al., 2009). Accordingly, sample size was deliberately planned to be relatively small to ensure detailed examination of each case in the study.

However, it should also be noted that due to the demanding nature of this research design, it was difficult to recruit participants to the research process. It seems that keeping a diary for a relatively long period time might have been considered as a burden by possible participants in their already busy schedules. So, because of this difficulty in finding participants; experience criterion which was set as minimum five years post-graduation experience at the beginning of data collection has been changed to three years of psychotherapy experience to be able to recruit more participants.

Thus, seven participants were recruited in the study. They were all female, even though it was not intended. Their years of experience were minimum three and maximum twenty-eight years (*M*experience = 9.86 years). All of them except two reported their bodily experiences with two different patients; two of them reported their bodily experiences with one patient (see Appendix F).

2.3 Procedure and Setting

Research design was based on diaries kept by therapists and semi structured in-depth interviews following this diary keeping process. Diary method was preferred in order to be able to record therapists' immediate bodily sensations during a session with a patient and understand their subjective experiences about these sensations. It was also aimed that diaries would serve as an important additional source of data which would enhance our understanding of therapists' subjective experiences along with in depth interviews.

Before data collection period began, an initial pilot study was conducted with a peer therapist to ensure that the structure of both the diary and the interview was flexible enough to capture participants' subjective experience in the process without constraining them with questions. The peer therapist was asked to monitor her bodily experiences in a session and write a diary in accordance with instruments intended to be utilized in research. After that, she was briefly interviewed about her experience.

Following the pilot and approval of ethics committee, the primary investigator (PI) and the advisor announced the study and inclusion criteria in relevant psychotherapy e-mail groups. Interested psychotherapists contacted the PI or the advisor via e-mail. The PI made a brief phone call with those psychotherapists and a short meeting was arranged with those who met the inclusion criteria in order to introduce the study and obtain their informed

consent. In that meeting, they were asked about some background information regarding their professional practice and therapeutic relationship with the patient of interest. They were also asked if they knew anyone who met inclusion criteria and might be interested in participating; those referred psychotherapists were also e-mailed by PI and those who were interested were included in the study following the same procedure.

Once they volunteered to participate, participants were asked to select two different patients who had been in treatment for a minimum of 8 sessions to ensure that relatively enough time had passed for therapists to become familiar with their patients and with their unique relationships with such patients. So, it was intended that bodily sensations emerging in countertransference could be examined by therapists in terms of the therapeutic relationship. Two different patients were preferred to be able observe a variety of bodily experience of a therapist in different therapeutic dyads. Participants were asked to monitor their bodily sensations as well as countertransference feelings for a period of eight sessions and to write their subjective experience after each session with those patients. They were not given paper based diary, they were told that they could write their reflections in their preferred way; either on a paper or via a computer. They were provided several questions as a guide such as perceived predominant theme in the session, perceived feelings of each parties and bodily sensations of therapists during the sessions and thoughts and reflections on these sensations (see Appendix D).

However, they were encouraged to write their experience in their own ways instead of sticking strictly to the provided questions. They were also strongly encouraged to include any experience that they observed in their diaries even though it was not listed in provided questions since it was intended primarily to explore and understand their subjective experience instead of merely collecting answers. Participants were given also a list of possible emotions and

bodily sensations so as to guide them identify their felt sense easily if they need to do so (see Appendix B and Appendix C). Once again, they were discouraged from sticking to the list and they were told to feel free to explore and write their own feelings and sensations which were not listed.

After diaries were completed, participants were invited to a semi-structured in depth interview, which lasted approximately 50 minutes, with the PI. Main reason why diaries were completed before the interviews were held was to be able to explore the lived experience of expanding clinical awareness by attending also to body in countertransference. Interviews were conducted in participants' private practice offices. All interviews were recorded via an electronic voice recorder with the permission of participants. In these interviews participants were asked to explore their experiences while monitoring bodily sensations and journaling. It was mainly intended to understand how this process of journaling their bodily sensations during the sessions affected their perception of therapeutic process as a psychotherapist, if and how they made use of these sensations and what kind of connections they made between these sensations and the therapeutic process.

After each interview, reflections regarding interview were noted by PI as an additional source of data (Gee, 2011; Smith et al., 2009). Moreover, in accordance with the purpose of this research project, embodied experience of both participants and the PI during interviews were attended and noted; they were also considered as a significant organ of information to extend knowledge on the topic at hand as emphasized by Finlay (2006).

Data collection period lasted approximately 9 months in total due to the difficulty in recruiting participants to the study as well as missed sessions because of holidays and patients' premature termination of therapy. In cases of premature termination, two therapists continued diary keeping with another patient and others who did not have an alternative patient were included anyway

although they journaled their bodily experience with one patient instead of two. This is because primary aim of this study was to understand participant's subjective experience about their body in the countertransference as a therapist regardless of variety of patients, thus it was decided that one patient would also be enough to understand therapists' experiences in such an explorative study and this should not be a reason for exclusion.

2.4 Ethical Considerations

Ethical approval was granted by Istanbul Bilgi University Ethics Committee. All participants were recruited on a voluntary basis, they were provided an informed consent (see Appendix A) and they were all informed about their right to withdraw at any time of the study without any consequences. Names and all other identifying information related to participants were kept confidential at all steps of the study and data were collected using participant numbers (T1, T2, T3, T4, T5, T6, T7).

Moreover, participants were not asked about any identifying information regarding their patients in order to ensure patients' confidentiality as well. Participants were asked to keep their patients' identifying information confidential, and also, they were strongly discouraged from including such information in their diaries and in the interview. They were asked to code their patients as Patient A and Patient B so that the researcher could differentiate between two different patients. Participants were strongly discouraged from sharing their session notes; instead, in their diaries they were asked to write their own subjective experience related to the session. In order to maintain patients' confidentiality, neither identifying information related to the patients nor

information regarding the content of psychotherapy beyond previously mentioned questions were asked in any part of this study.

The interviews were recorded using an electronic voice recorder. All data were stored in an encrypted folder in the researcher's computer.

2.5 Data Analysis

The data consisted of written diaries kept by each participant wih two different patients for eight weeks [a total of 96 individual diary entries] and seven interviews conducted with each participant. Handwritten diaries were transferred to number lined document by the PI. All interviews were audio taped and then transcribed verbatim and all data were analyzed via MAXQDA software. Before the coding process, each transcript and diary was read and re-read and associations and reflections were noted using memo function of the software. At this point, PI's reflections noted following the interviews were also taken into consideration. Having been familiar with data, firstly descriptions of participants' experiences and understandings were noted with a close line by line analysis in each case individually. Language usage and unique expressions of participants were noted as well. All diaries and transcripts were coded for each case rather than utilizing diary entries merely as a supplemental data to transcripts. Initial findings were discussed with the advisor in terms of interpretation and consistency for the inter-coder agreement. Accordingly, emergent themes were identified for each case separately and then cases were compared in terms of commonality and divergence. In line with findings, emergent themes were clustered and superordinate themes were built up.

2.6 Trustworthiness

Trustworthiness of the study were aimed to be enhanced in several ways. Firstly, data were collected employing multiple methods which is one of the strengths of this study; diary method was employed to be able to understand immediate subjective experience regarding bodily phenomena, and then with in-depth semi structured interviews a detailed examination of experiences were provided. Themes were identified utilizing both individual diary narratives of participants and interview transcripts. Thus, immediate experience was also received along with the retrospective account. Moreover, bodily experiences of PI and participants were observed as an additional source of data and included in reflective journal of PI which were again utilized as an additional data source. Secondly, the thesis supervisor was part of each step data analysis process as a triangulated investigator and consistency was established between two investigators in terms of final results. Thirdly, a peer researcher reviewed interpretations and themes before finalizing the themes. Then, themes were sent to participants via e-mail to check their reflections on whether those themes represented their experiences in the process. Six of them answered back and confirmed that themes reflect their experiences in the process.

RESULTS

Five main themes emerged as a result of Interpretative Phenomenological Analysis: (1) Mind vs. body, (2) Bringing the body into the room, (3) Bodily experiences, (4) Working with somatic countertransference and (5) Getting in touch (Table 1). Each theme and sub-themes are defined and discussed below and direct quotations are used to illustrate the themes. Quotes are labeled as T1, T2, etc., (e.g. Therapist 1, Therapist 2) for the readers who may want to follow experiences of each particular therapist. The source of information, interview or diary, is also labeled as D for diary and Intw for interview. For instance, T2-D refers to Therapist 2 and source of information is diary of that therapist while T5-Intw refers to interview of Therapist 5. Yet, diaries kept with different patients were not labeled in results to ensure further patient confidentiality.

Table 1

Summary of Themes

Themes	Subthemes
Mind vs. Body	the neglected body
	the fear of body
	the body as a burden
	verbal emphasis
	limitation of words
	verbal body and embodied language
Bringing the Body into the Room	therapists' subjectivity
	therapists' bodily awareness
	openness to bodily experience
Bodily Experiences	sensations in the stomach
	sensations in the chest
	pain
	sleepiness and dissociative experiences
	body posture and muscles
	crying
	sensations in teeth
	itchiness
	other bodily experiences
Working with Somatic Countertransference	the body as a guide
	the effort to distinguish the source
	closing off the body
	staying with and reflecting on sensations
	regulating
Getting in Touch	getting in touch with body
	getting in touch with patient

3.1 Mind vs. Body

In the interviews and diaries, mind and body mostly appeared as if they were in a competition with each other and this competition emerged as six subthemes; the neglected body, the fear of body, the body as a burden, verbal emphasis, limitation of words, verbal body and embodided language. 'The neglected body' depicts the therapists' experiences of body in the process as it was mostly left out of therapy room; it was neglected and forgotten. Moreover, 'the fear of body' in therapy room was also striking. The experience of attending to body in the research process was also considered as a burden which is detailed in 'the body as a burden'. Accordingly, 'verbal emphasis' portrays how therapeutic work was defined as mostly a mental work thus with an emphasis on verbal activity over body. However, words alone seemed to the therapists as inadequate to express lived experiences and 'limitation of words' describes this experience of limitedness regarding words. Thus, it was observed that lived experiences were expressed with an embodied language while, on the other hand, body appeared as if communicating via verbal means of communication; it was depicted by participants as though it is 'talking' rather than communicating in nonverbal ways which is explained in 'verbal body and embodied language'.

3.1.1 The Neglected Body

All participants indicated that they somehow either neglected or forgot their bodies in sessions. Body seemed as if it is separated from the subjective being of the person and kept out of reach. Accordingly, a therapist expressed her feeling of being disconnected with her body: "it is so disconnected that as if I am carrying my body as a bag with me" (T7-Intw). Body was considered by the participants as something that no one is aware of its existence. A therapist commented on her being disconnected with body: "There are some other parts of me below my head and I realized that I had no connection with those parts at all" (T6-Intw). Similarly, another therapist commented on her bodily neglect in sessions:

> There is this concept in cognitive and neuropsychological tests called visual neglect. People do not see one side of paper when they look at it. I felt like, in my perception, something is shut down below my head. There is this habit of inactivating below head (T1-Intw).

Body was inactivated somehow and was out of the therapists' sphere of attention: "When one does not pay attention particularly, that can become something went unnoticed" (T4-Intw).

Even in the scope of this research project which asked therapists to pay attention to their bodies in sessions, they found it difficult to include their bodies in therapeutic work. One of them stated: "In terms of monitoring my body, I realized that I forgot it. I inactivate it" (T2-Intw). Another therapist also mentioned she forgot monitoring her body in sessions during the diary keeping process: "I realized sometimes I forgot my body, thus it is not included in notes as well, I realized I did not attend to it at all" (T5-Intw). Even though one tried to pay attention to body in therapy room, it seems that body remains in the

background of mind: “I monitored my sensations, but mostly I monitored my mind. The body was in the background, it was talking with a low voice” (T2-Intw).

It was also remarkable how it was particularly left out of therapy room even if therapist was engaged in her body in her personal practice:

> I have been engaged in body, dance and authentic movement for a long time but when I am with patients that aspect is left out of room, it is my personal practice. It is not something I do with patients; so, it was interesting for me since I utilize what I feel in my body in my personal practice but not in therapeutic field (T1-Intw).

Thus, there must be something going on with body particularly in the therapy room that causes therapists to avoid it.

3.1.2 The Fear of Body

It seems as if there is a fear of body in the therapy room. Some of the participants indicated the fear regarding visibility of one’s bodily experiences: “I felt nauseous and I thought that I hope this nausea is not perceivable by looking at my face” (T4-D). Therapists were trying to hide their bodily experiences: “I usually try to hide my yawning by clenching my teeth so that patient does not see it” (T3-Intw). Another therapist also noted: “I tried really hard to prevent patient seeing me yawning” (T4-D). Visible bodily experiences seemed to be controlled and eliminated. A therapist stated: “I tried to control my tears” (T7-D). She further explained: “I think I was not ready to do this in front of the patient and I think that the patient was not ready to see this either” (T7-Intw). It

was implied that one should be prepared first to make bodily sensations visible in the room. It requires preparation not only for patient but also for therapist.

Furthermore, body was depicted as a frightening place: “It is also a frightening place, I get afraid too but at least I was able to work on it” (T7-Intw). In a similar manner, another therapist explained the reason why she ignores her body in therapy room: “I ignore them and interpret other things, I am trying to look the other way, trying to stay in mind. It feels much safer” (T5-Intw).

Body was an uncanny place that one can go inside and what could happen is in that place remains unknown. A therapist remarked regarding attending body in sessions: “One can fear the unknown” (T1-Intw). One can also get lost in that place: “It can be a little bit frightening sometimes. What if I got lost, I could not listen” (T5-Intw). Moreover, one needs a courage go inside of that place:

> I was always curious about this and actually, I always wanted to get involved. Some people told me to begin exploring with yoga, or to participate in dance therapy etc. But I could not do it, I could not work up the courage, I don’t know why (T6-Intw).

Accordingly, body seems to be very intimate. A therapist commented on her avoidance of body in therapy room and explained her experience in the process as “sharing bodily experiences and emotions which arose from them felt as if being exposed” (T5-Intw). She further elaborated:

> If telling someone about patient is level one, telling about patient’s current situation is level two, telling about my interpretation in sessions is level three and telling about my countertransference and their transference is level four but the top level and perhaps the most intimate one is telling about bodily experiences. Because, all interpretations and

> countertransference, and transference is directly linked to ourselves, but this is my very own body, this is much more related to myself, more of an insider about my situation (T5-Intw).

Similarly, another therapist expressed her experience of realizing dynamics in therapeutic relationship via her body: "I thought that I and my own subjectivity may be the reason and this made me feel somehow ashamed while writing this diary" (T6-D). In another entry in the diary, she also noted: "I felt ashamed sometimes since this situation will be observable in the research and I did not want to write" (T6-D). Thus, the uncanny feeling of unknown was apparent in terms of fear of body, mental work was "much safer" (T5-Intw).

3.1.3 The Body as a Burden

Attending to the body also seemed to be a burden for many participants. Many of them expressed their feelings in terms of monitoring their bodily experiences as tiring. A therapist noted how enriching the experience was but also noted: "On the other hand, I realized that I really felt tired" (T1-Intw). Similarly, another therapist indicated: "In sessions, I tried to monitor what happens in my body in that moment and I think it was demanding for me especially at the beginning" (T5-Intw).

Including body in therapeutic work was considered as an extra burden for therapists. One therapist described the process "It was exhausting, it made me feel exhausted" and she further stated: "It is as if tracking an additional aspect. Ok, now there is another thing that I should take into consideration as if we had not enough, maybe it is a little bit irritating. I mean there are already too many things that we should track and now this came up" (T3-Intw). It was implied that

therapists already have a lot on their plates. Another therapist also noted: “It is difficult. You know we track too many processes as a therapist, and now it comes to the questions when did it start, is it in this part or there etc. it is certainly difficult” (T2-Intw).

It was experienced as if there were too many dimensions to attend to in a session:

> I felt as if there are too many different voices inside of me, I thought I did not have that space, openness and capacity to listen all of them at the same time. I thought to myself that now should I think these as well along with too many things? (T6-Intw).

However, it was also remarkable that burden was mentioned by participants, except one, who defined their relation to their bodies as poor and had the most difficulty to bring body in therapy room.

3.1.4 Verbal Emphasis

Many participants referred to a verbal or mental emphasis in their sessions. The way of therapists’ being in a session was depicted as a mental being. A therapist indicated that “It seems as if I am present in a session merely mentally” (T5-Intw). Another therapist also noted: “I have always something in thoughts and feelings, not much in sensations” (T2-Intw). Even if one made a great effort to include body to sphere of attention in session, it was difficult for body to compete with mind:

> I was setting an alarm in sessions so as not to forget, because I really forget it. I have a vibrating alarm here which reminds me; do not forget

> body, watch what happens. When alarm did not work, sometimes I realized, 20-25 minutes later, like oh no I forgot! In a sense, only my mind comes into play, I only think, grasp with my mind (T1-Intw).

In this competition of mind and body, mental work seemed to suppress body. Many therapists pointed out that they were not aware of their bodily experiences in sessions they were verbally active. One of them explained: "There were no sensations I was aware of. I think the reason why I did not feel any sensation is that it was more like a mental session" (T7-D). Another therapist stated: "In this session, my focus on what to do or not, boundaries and mental work was so intense, and I understood that I did not realize any change in my body" (T5-D). Let alone notice a sensation in body, it seems that it was difficult even attending to body when there was verbal emphasis in a session: "When I talk more than usual in a session, when I was much more active, probably I never even attended my body in such sessions" (T3-Intw).

Futhermore, verbal content was regarded so important in sessions that therapists indicated that they felt nervous when they shifted their attention from mental work to body: "This was one of my first diaries. Since I was trying to observe my body in the session I have become nervous since the beginning of session. I thought as if I cannot listen to the patient" (T6-D). When a sensation emerged, it was ignored to attend the primary focus of therapeutic work; verbal content: "I think I did not focus on sensations that much when they appeared since I don't know maybe I was anxious about what if I missed the flow, the content" (T4-Intw).

Moreover, it is worth to mention that there was a verbal emphasis also in interviews conducted with those who mentioned such emphasis most. It was remarkable that they often explained their experiences in terms of their mental work rather than expressing their bodily experiences.

3.1.5 Limitation of Words

Despite the emphasis on verbal activity, most of the participants referred to the limitedness of words as well. According to them words were not enough to express their experiences. They commented that words alone not only fail to connect patient's experience, but they were also limited in terms of expressing their bodily experiences in sessions. According to a therapist: "It is something that you understand by experience, but it is very difficult to express in words (T1-Intw).

Similarly, one of them explained her experience of verbalizing their sensations for diary: "I thought about it since it is so related to feeling for instance the fact that muscles freeze, they become tense; they are not something explainable, not by writing" (T7-Intw). It seems there is a gap between words and experiences. Accordingly, another therapist indicated that "Well, this is, expressing in words is difficult part for me" (T3-Intw). She further explained: "I mean; if it remained as thoughts and feelings, it would be easier but verbalizing that experience, that feeling was too difficult for me" (T3-Intw). Moreover, another therapist also indicated that verbal communication is not enough to understand patients' situation: "There is no way to understand with mind that he cannot digest" (T1-Intw).

A therapist also commented on limitedness of words:

> Well, I think words are limited. Okay we tell something; how we get upset, how we get scared but that bodily experience, uhm, there is a difference between saying I was afraid and feeling such terror. It seems to me that probably since this i originates mostly from the preverbal phase, it is so communizing, it feels as if being in the same boat with the patient. After all, we all have been there (T4-Intw).

A therapist, in a similar manner, expressed how she feels as if something is missing while working with words alone:

> If I surrender myself to his management of session, we keep going like that: He tells me something, I interpret, he grasps the interpretation, he reflects on it and it goes on like that in an intellectual level. However, I realize after a while something remains missing in this, I felt as if I have a tool for inviting him to a different level" (T5-Intw).

Additionally, in the interview, a therapist described her bodily experience in a session via bodily experience by referring to a common experience rather than using words:

> It felt like as if there is nothing holding. I don't know if you have the same dream ever but there is this dream that many people have. It is as if you are falling and the moment when you are about to hit the ground you wake up. Have you ever had such a dream, it felt like that, as if floating in the air (T4-Intw).

Furthermore, I believe this explanation would enable many readers to understand this experience better by relating their previous experience.

3.1.6 Verbal Body and Embodied Language

It was remarkable that somehow body appeared as a concept communicating verbally whereas verbal expressions have reflections of body. Namely; for participants, body was 'talking', as though it was using verbal communication rather than nonverbal communication. On the other hand,

language that used by participants were colored by bodily experiences. Body was verbalized while language was embodied.

A metaphor of talking body was apparent in the process. Many of the participants explained their experiences of of attending to their body as 'listening to the body talk'. According to a therapist: "Perhaps the body is talking to us all the time, but we don't hear it" (T7-Intw). One of them explained: "It is as if keeping your ears open, trying not to miss anything" (T4-Intw). Also, another one noted:

> The more I can pay attention and I can give an ear to my body, the more it speaks to me. Perhaps, in the future if I could be a good listener in terms of my body it would tell me more (T5-Intw).

Another participant noted "I felt like a hypochondriac, I mean I can understand those people now. I don't know, maybe the more you listen, the more you want to listen" (T6-Intw). One of the participant also stated: "I think it is as if making room for listening to the body" (T7-Intw). Another one also stated: "It was interesting to observe unconscious communications, to be able to listen to the other dialogs, talks" (T2-Intw). Thus, body was clearly communicating something, but it was striking that body communicates it by speaking.

On the other hand, embodied aspect of language usage was also remarkable. A therapist expressed her grasp of fear as if "having a cold sore on lip" which is a common expression in Turkish referring to being terrified (T4-Intw). Moreover, while referring to what she did when she noticed the feeling of tension in session a therapist expressed how she tried to be calm with an embodied idiom: "I kept my feet on the ground" (T2-Intw). Similarly, one of them also noted: "I felt dizzy because of rapid change in her affect" (T4-D) which is again another expression commonly used in Turkish. Additionally,

another therapist mentioned “something that cannot be digested” referring to patient’s difficulty to embrace and process the interpretations.

3.2 Bringing the Body into The Room

In the process, another theme that emerged was related to *how* these bodily experiences emerged in the sessions. Several factors that influenced the emergence of sensations were articulated by therapists. Therapists’ own subjective history including bodily history was mentioned as an important factor in terms of emergence of bodily sensations. Similarly, therapists’ bodily awareness prior to this study and their openness to bodily experiences was another important aspect in terms of monitoring such sensations in sessions.

3.2.1 Therapists’ Subjectivity

All participants in the study commented on therapists’ subjectivity in terms of emergence of sensations in session. Many of them associated sensations with therapists’ own subjective history and especially with therapists’ bodily history. A therapist expressed her feelings about her sensation of cold sore on the lip by referring to her own subjective history:

> For me cold sore is really meaningful, and it was also very related to the material that patient was talking about, because she was talking about her fear of intimacy and for instance when the boy I really like makes a move on me I knew I get terrified and saying oh no it’s happening, and I had

cold sore on my lip. I don't know, well, also what patient was telling me reminded me of that feeling (T4-Intw)

She further noted that "I think that what the patient tells me echoes with something related to body about my inner world. Then I return and make sense of it for both of us" (T4-Intw). Another therapist also emphasized her subjective contribution to aroused sensations: "Some part of it is related to me, for sure, to my internal processes" (T5-Intw)

A therapist commented on her most frequent feeling and sensations in the sessions as:

I do not know if it is a selective memory or not, but anger is the emotion that I attended to the most and since it is the emotion that I wanted to control most, probably I am most aware of that rather than the others. Possibly that is my concern these days. These experiences related to anger in sessions with Patient A look familiar to me. That happened to me with different patients and at different times as well (T6-Intw)

Another therapist also commented on therapists' contribution:

Well, patients' psychodynamics, uhm, my sensations. I think some parts of it are about me for sure. Nothing happens unilateral in sessions. I have my own psychodynamics too. Maybe a patient whom I really feel sad with, well perhaps everyone approaches very empathetic to their patients with really sad story or can feel that sadness, but I am not sure if everyone experiences such sadness in the same way. If it is sadness, everyone experiences such sadness but how do they experience such sadness? I think that it depends on who the therapist is and what they bring about themselves into the room (T7-Intw).

3.2.2 Therapists' Bodily Awareness

Another aspect that was considered as an important one for bringing body into the room was therapists' awareness of their own bodies. For instance, a therapist who is engaged with her body in her life even before this research, even though she did not attend to it in therapy, explained how she experienced an absence of familiar sensation:

> He is telling me about a very sad situation, he is telling as if he was feeling so sad, but I feel nothing. Well, I tell myself, I know if someone feels sad; I feel it usually in this area [puts her hand on her chest] but I do not have that sensation, I feel only emptiness inside. No sensation at all, well then, wait, he is telling me about sadness, namely this is what his words tell but what I am feeling inside is telling me something else so wait, and see what this really is. This is a different level because what my mind and eyes telling me, when I see him, I can tell by looking at his face that he is so sad. But I have emptiness in my body. If there is sadness I know very well that I feel it here. I usually feel sadness here, in session with him as well. But at that moment I did not have that sensation (T1-Intw).

Those who described their relation to their bodies as poor (T2, T3, T6) explained how they find it difficult to notice any sensation in their bodies. One of them stated: "I felt inadequate thinking why I do not feel any sensation" (T2-Intw). Another participant also explained her feeling of inadequacy and having difficulty in naming sensations:

> I really had difficulty to name sensations. I thought; what is this called, what was this? I really had difficulty in finding words and naming them. It made me have really strange feelings: why can't I define this, why can't I find words to describe? (T6-Intw).

One participant also remarked such difficulty in naming sensations:

> You had given me a list of sensations, in fact I can define many sensations as stomachache but in that list, there are three or four different sensations. I mean, stomach rumble is different sensation or stomach cramp is different, but I can name all of them as stomachache. I realized I cannot exactly name these sensations in my life. It is similar to those patients whom you ask how they feel but they tell you: good. Okay but what is that? Is it happiness, well, are you surprised, does something good happened to you? etc. I realized I put such sensations in the same category (T3-Intw).

3.2.3 Openness to Bodily Experiences

Therapists' openness to bodily experiences was another important aspect of emergence of sensations in the room. A therapist stated "I attribute it to openness, being open to different channels of communication. Not merely what is told verbally" (T4-Intw). Moreover, another therapist depicted the opposite situation: "It is like having blinders on" (T3-Intw). It implies a breaking habit, moving away from the comfort and familiarity of routine even for a limited period. A therapist stated "To allow wandering and to know being able to come back. Even if I am in the room, allowing such experiences for a few minutes is enriching" (T5-Intw). This breaking routine was not experienced as an easy action. One of the therapists explained her difficulty in attending to body in terms of her bodily resistance: "I think at first there was a resistance in my body, I mean, it had been there for a long time, but it manifested itself there. It was like a resistance that I could not go with the flow" (T6-Intw).

Moreover, for some people it was not that easy to offer their bodies to experiences. A therapist explained her realizing sensations in session "probably that was a moment that I was open and felt it" (T2-Intw). She further explained how she is guarded most of the time:

> I am mostly closed off. I mean, I may get easily affected by the emotions and thoughts of others. I think I am more of a receiver type of empath and usually this may be compelling for me while working with many patients in a day. For instance, I usually walk in the streets looking at the ground, I do not have eye contact with people. Because something may get in very suddenly when I am unprepared, I mean, that emotion can get in very powerfully (T2-Intw).

It seems that bodily experience can catch one off guard. Similarly, a therapist also commented on not being aware of bodily experiences: "When maybe we close ourselves off as a defense, when we tell ourselves that I should close myself off and move on; that connection can be lost" (T7-Intw).

3.3 Bodily Experiences

The focus of this theme is to provide an account of therapists' various bodily experiences in the process other than previously mentioned experiences. Recurrent experiences in the process were merged as subgroups however unique experiences that were mentioned by only one participant were not excluded in order to provide an account of the variety of bodily experiences. Moreover, some of them were reported more than once by the same participant but in different ways. They were included below again to present the variety of reported sensations in the research process. These bodily experiences can be grouped as

sensations in the stomach, sensations in the chest, pain, sleepiness, body posture and sensations in the muscles, crying, sensations in teeth, itchiness, tension and relief in body, dizziness and some other unique bodily experiences.

3.3.1 Sensations in the Stomach

All participants in the study reported sensations felt in their abdominal region. Several therapists reported stomachache and stomach spasm (T1, T2, T3, T6). One of them described: "I felt an unpleasant discomfort in my stomach" (T2-D). In another session, she reported: "I felt a pinching sensation in my bowels while the patient was crying for her ex" (T2-D). Unpleasant, unwanted parts of affect seemed to be experienced in the stomach. Accordingly, another one reported heartburn: "There were some moments that patients' anger which he did not bear and tolerate affected me and thus I felt down and desperate. Heartburn was quite intense in such moments" (T6-D).

Movements in the stomach were prominent in both diaries and interviews. One therapist reported "stomach rumbling" (T7-D). Also, anger was experienced in stomach as moving: "An anger moving upwards from abdomen" (T1-D). Similarly, fear was experienced as stomach movements: "Simply a reaction of fear: I mean I felt nervous and there was a movement in my stomach" (T5-Intw). Besides fear, emptiness was also experienced as a movement in the stomach: "Sometimes you feel emptiness in your stomach, sometimes it flows upwards" (T1-Intw). For some therapists, such movements were related to something that cannot be digested and removed out of body. One of them considered that this experience was related to patient's anger that cannot be expressed: "It is as if not being able to make one's toilet; it twirls and twirls. It is like old washing

machines, it twirls and twirls, but it does not have an out" (T1-Intw). Another one also noted: "I realized a bowel movement and while writing this diary, I thought that this might be related to patient's history of Irritable Bowel Syndrome. There might something that cannot be digested and removed out of body" (T6-D).

It was experienced as taking too much inside of the body. A therapist mentioned "I felt bloated as if I ate too much while talking about fat" (T5-D). A therapist, on the other hand, commented on difficulty in taking in something in the first place:

> I noticed that my stomach was bloated. I think it is related to digestion of something or maybe taking them in, swallowing them. I mean this 'child' is so immature, so raw that it seems as if he could not take in somehow any good object. I say 'child' but he is an adult indeed. I think he could not take in, he could not eat, could not get enough, I think he starved (T6-Intw).

Sensation of bloating was associated directly with the digestive system: "An indigestion in stomach. A disturbing feeling moving upwards in the opposite direction of digestive system" (T1-Intw). According to therapist, patients attitude was trying to eat more food when she was already full: "Is my bloating that kind of difficulty to digest?" (T1-D). Similarly, gas pain was also considered in relation to digestive system, a therapist wrote:

> I came home, I am having an incredible gas pain, I feel like myself as if a mother who is walking around and patting a baby who has gas pains at night. Nothing relieves the pain of a young digestive system – a basic newly acquired digestive system (T1-D).

Another therapist also noted how she felt as if dealing with a baby who could not be soothed: “There is a baby somehow who could not be degassed” (T6-Intw). Taking in interpretations and processing them also was associated with such sensations in the stomach:

> There is something that cannot be disgested. She is a baby in her own psychic world, she is as if a baby whose bowels never developed so if you give a banana to that baby, it is not possible for her to digest it (T1-Intw).

Additionally, several therapists reported hunger in sessions (T4, T6, T3). One of them noted: “While talking about need of care and affection, I felt really hungry” (T4-D). Hunger was associated with needs: “I thought that I could not be hungry yet. Then I realized that patient did not pay me yet for the session she did not come without notice” (T4-D). Moreover, greed was also considered in relation to hunger: “With a patient who has a weight problem and always talks about food and hunger, I feel hungry. It is like a hunger of a nursing mother, as if she drained me” (T4-Intw).

In addition, several therapists reported nausea (T4, T6, T3). It was apparent in times when content was overwhelming for therapist: “I felt like this theme was too much for me” (T6-Intw). Another one emphasized disgust regarding the content “Well because she tells really disgusting things and first of all she tells them vividly and makes you live it” (T4-Intw). On the other hand, another therapist mentioned her experience of being devalued: “I think the fact that he devalued me led me feel nauseous” (T3-Intw).

3.3.2 Sensations in the Chest

Sensations experienced in the chest was also common. Some therapists reported a tightening sensation in the chest. A therapist wrote in her diary: “the tightening between my breast” (T1-D). She further explained: “I sometimes confront her, and I think she does not like those confrontations. And at such moments I feel I am tightening inside” (T1-Intw). Another one associated this “sensation of tightening in chest” with prominent affects of anger and tension in session (T2-D).

Besides, many therapists reported bodily experiences related to their breath as well (T4, T6, T7, T1). A therapist wrote: “I feel as if I am short of breath” (T1-D). Also, one of them explained how her breath is affected by the theme of anger in session: “In my part, I felt panicked and room felt smaller” “I could not breathe” (T6-D). Moreover, sensations related to breathing were mostly present for T4 and fear of separation and abandonment were also considered in relation to difficulty in breathing: “I noticed that I was holding my breath. I had to remind myself to breathe again. This experience of ‘being out of breath-breathing again’ reminded me somehow of a theme of loss (T4-Intw).

Theme of loss was prominent and shortness of breath was also associated with despair when being abandoned. She further noted:

> Being abandoned by mother but not being able to make sense of it. I mean, a baby cannot understand whether it was a loss or not. She is gone, but will she come back? Huuuh (sound of not being able to breathe) a near to that experience, it reminded me of that (T4-Intw).

Also, the same therapist explained her experience of suffocation and despair during a session with a patient. She later learned about this patient's early history of being suffocated:

> I thought I was suffocated. I felt really thirsty, it was such an intense experience of suffocation I think there is no way that I can tell. I tried to open the window, I could not reach it, I tried to drink some water but I noticed I had not brought a water in the room. Damn! I will not survive till the end of session, I will die here. It was like fifth second of session and I felt the same for forty minutes more (T4-Intw).

Similarly, another therapist also mentioned loss in relation to breath referring to death and rebirth themes: "Theme of death and rebirth led to shortness of breath" (T6-D).

Moreover, suffocation with patient's intense need of intimacy also was mentioned: "I thought whether this is her need of being emotionally suffocated, I mean she needs intimacy so much and I will be suffocated in such need" (T4-Intw). It is also worth to mention that the therapist also felt suffocated during the interview while talking about this experience.

Besides such experiences of suffocation, another therapist explained how her breath deepened: "My breath deepened while I was listening to her. I mean I realized I took in more breath inside of me" (T7-D). Moreover, with another patient she noted: "I realized I was letting out more breath while speaking" (T7-Intw).

Additionally, sensations related to heart was also common. A squeezing sensation in heart was apparent for T4. She mentioned: While I was listening patient's monotonous life, I noticed a squeezing sensation in my heart" (T4-D). She also expressed how anger caused her to feel such squeezing sensation:

"While patient was telling their conversation, I felt that my heart squeeze because of anger" (T4-D).

Also, another therapist explained how she experienced anger with a fast heartbeat: "Patient was talking about an argument that made him so angry, it took a while for him to calm down by clenching his hands and taking deep breaths. This led a fast heartbeat and clenching hands in my part" (T6-D). She also explained how she noticed that she experiences her anger in general: "When patient addressed me angrily, first I noticed my hands are sweaty and then my increasing rapid heartbeat" (T6-D). Another also therapist mentioned her fast heartbeat before an interpretation that she thought as an important one: "I remember that I had hard time to remain silent without making any interpretation and waiting her to finish impatiently. At that moment, my heart was beating rapidly" (T5-D). She further associated her experience with "anxiety" (T5-Intw).

3.3.3 Pain

Pain was also one of the frequently reported sensations in the process. Two therapists reported headache in sessions. One therapist mentioned: "I may excessively engage in what he tells and when I pay attention that much, I have headache" (T3-Intw). Another one explained how she experienced the patient's experience: "I was having a throbbing headache and after a while in the same session I learnt that patient hit his head" (T2-Intw).

Other therapists reported neck pain and back pain in sessions. One of them associated such experience with a burden of responsibility: "I have difficulty in carrying patients, taking responsibility of them, helping them to get better and I think these pains are somehow related to this difficulty" (T6-Intw). Similarly,

another therapist also mentioned burden and responsibility in relation to back pain: “I felt pain in my back and I reminded myself what this situation brings is not burden but a responsibility” (T2-D).

Another therapist mentioned “eye pain” in the face of a sudden change of content and affect in session (T3-D). She further explained her exhaustion: “I think it is kind of a reaction as if I do not want to see this anymore” (T3-Intw).

3.3.4 Sleepiness and Dissociative Experiences

Many participants mentioned some bodily experiences which were a kind of moving away from the present moment in the session. Sleepiness which was a common bodily experience in the process (T3, T4, T5, T2), can be considered one of those experiences. It was considered in relation to narcissistic tendencies: “My eyelids felt so heavy that I thought I fall in sleep and I could not endure till the end of the session. I thought this boredom and need for yawning was related to narcissistic tendencies of patient” (T4-D). Boredom also was associated with sleepiness: “I can be literally bored sometimes” (T4-Intw). Another therapist also explained: “If it is a patient who fills the session with so many fact-related content without any emotion then it makes me sleepy” (T5-Intw). Also, recurrent themes leading to boredom and exhaustion in therapists were mentioned in relation to sleepiness: “I felt sleepy. Insistent, repetitive and unchangeable pattern of this theme leads me to feel hopeless and exhausted” (T2-D). Similarly, while listening to a repetitive theme another therapist wrote “I yawned during the whole session” (T3-D). A therapist explained how she make sense of such boredom and sleepiness in a session: “I think that when I feel really bored and sleepy, there is something sleeping, inactive somewhere inside of patient” (T5-

Intw). Therapists in the study mentioned that they became more disconnected in such instances and became somewhat inactive in sessions.

On the other hand, more dynamic and lively sessions were regarded as revitalizing and therapists felt more engaged in session: “It was overall a cheerful session, he rested and relaxed. I also feel the same. Session felt as if shorter than usual, it ended very quickly. Although I was very tired normally, I did not yawn even once” (T3-D).

In addition to sleepiness, some experiences that can also be regarded as a kind of disconnection in session were reported by participants as well. A therapist wrote: “I experienced something dissociative. It was so close that I only saw her, really saw her, heard only her affect and background got blurred, it was like a denial of therapy room that we were in” (T5-D).

Also, two therapist reported dizziness in sessions (T4, T6). One of them explained: “I felt dizzy because of rapid change in her affect” (T4-D). Additionally, she commented on another experience of dizziness in session that boundary was the main theme: “I felt dizzy after session, my blood pressure went down; I felt as if, I have no ground. I thought later that this was fear caused by patient’s having no boundary” (T4-Intw).

Other therapist explained her fear related to upcoming surgery of patient and explained: “I felt as if I was in a surgery room and I have cuts on my arm. I felt dizzy because of intense pain” (T6-D).

3.3.5 Body Posture and Muscles

In the process therapists also reported that they noticed some changes in their body postures and sensations in their muscles. For instance, when being devalued, a therapist referring to power struggle dynamics prominent in the relationship stated: “I realized that I was wallowing in despair and I noticed that I was trying to sit taller and even trying to look taller and bigger than patient” (T3-D). Also in another session, she mentioned “sliding down in chair” which is according to her a “regressive act” referring to such power dynamics. Also, another therapist indicated a similar body posture while patient was talking about importance of being powerful and standing tall: “I noticed I was sitting slouched” (T2-D).

In another situation in which the patient was talking about his birth, therapist felt as if she was delivering a baby and mentioned: “I noticed that I was sitting my legs open, as if sitting in a gynecology chair” (T3-Intw). On the other hand, sitting legs open also referred to a masculine position: “I noticed that I was sitting my legs open while my patient was talking about mansplaining” (T3-D).

Stiffness and tightness in muscles were also frequently mentioned. A therapist mentioned “tightness in her muscles” and stated that it was as if “someone squeezing my body” (T2-Intw). A therapist mentioned such stiffness when feeling nervous: “I noticed a stiffness in my leg muscles in sitting position” (T5-Intw). Stiffness and tightness in body was associated with flexibility of mind. Another therapist mentioned a stiffness in muscles of whole body and stated: “The stiffness in my body reminded me stiffness of my mind. I could not feel any flexibility” (T7-D). “Loose muscles” were also reported (T7-D). When muscles and body were relaxed it seemed that mind can also flow in such flexibility.

Tension and relief were also common sensations which were mostly affected by the flow of the session. Tension in the body was especially present for T2. She reported tension in her body especially when tension was apparent in session: “Tension in my body was wakening me. We were both attentive and on alert with a tension” (T2-D). Tension was experienced in line with both parties’ experiences of alertness in the session. When such tension was relieved it also had reflections on the body as well. In another session, she mentioned: “I noticed that session content became coherent and consistent and I felt a relief in my body with an intense feeling of contentment” (T2-D). Another therapist also mentioned how her body was relieved after an interpretation: “She was filled with tears upon my interpretation and I felt a relief in my body and my sitting position” (T5-D). Also, a therapist mentioned how body “relieved and felt lighter” (T7-D).

Similarly, two therapists reported heaviness in the same context; one of them mentioned “heaviness in chest” (T1-D) and the other one mentioned heaviness in whole body: “I felt like heaviness was a reflection of the fact that she communicated her feeling of being down to me” (T7-D). On the other hand, in another session she reported “lightness, flow and vitality in body” (T7-D).

Also, some therapists reported tiredness in their body (T2, T5). One of them explained in a session with intense mental work: “I realized I leave these sessions with a tired body” (T5-D).

3.3.6 Crying

Several therapists reported that their eyes filled with tears and they felt as if they were going to cry in sessions (T7, T6, T4). One of them stated that “as

patient talked about separation and cried, my eyes filled with water" (T6-D). Sadness of patient was also experienced by therapist. Even when patient was having a difficulty to cry, therapists was there to experience such feeling: "My eyes filled with water twice and in both, patient was talking about a very painful experience but having a difficulty in crying" (T7-D). Similarly, affect that was to emerge in a session was apparently firstly experienced by therapists: "I feel sad somehow for no reason, my eyes were filled with water and I could not make sense of it" (T4-D). Therapist explains that later a very painful experience related to that content emerged in session.

3.3.7 Sensations in Teeth

Clenching teeth was also reported (T3, T2, T7). It was considered in relation to anger: "He was too flirtatious in this session. I noticed that I clenched my teeth for the whole session" (T3-D). She further explained: "I remember I did that due to anger, his attitude irritated me" (T3-Intw). Moreover, being nervous was also associated: "I was feeling tense and I noticed I clenched my teeth" (T2-D).

On the other hand, toothache was experienced in relation to separation: "I noticed I had a toothache". Therapist made sense of experience with a personal meaning of sensation: "Tooth symbolizes death in my cultural environment, so I thought it might be related to the idea of separation is equivalent to death while writing this diary" (T6-D).

3.3.8 Itchiness

Itchiness was also mentioned in the process. A therapist reported an "itchy throat" in a session (T3-D). Other therapists also reported "itchiness in body" (T6, T7). And one of them explained: "I felt down and desperate and itchiness and heartburn accompanied these feelings" (T6-D).

Another therapist reported "an itchiness in palm" and associated it with patient's greed: "Giving or receiving money? Patient always wants to receive without giving any. She is a greedy baby who never gets enough" (T1-D). Similarly, greed was considered in relation to sensation of itchiness by another therapist as well. While a patient talking about her sexuality and indeed talking about her greed according to the therapist, therapist experienced: "I felt my breast was itching, and then an imagery of unpleasant moment of breastfeeding was emerged in my mind, I did not utilize it, but I thought how hungry she could be for love and affection" (T4-D).

3.3.9 Other Bodily Experiences

Other than bodily experiences that were grouped in previously mentioned categories, there were some unique experiences as well.

A "feeling of cold" also reported while patient was telling a memory which took place in a cold night but did not expressed that she felt cold (T5-D).

Another therapist stated: "My patient was talking about her intense fear of intimacy and I felt a burning sensation on my lip as if I would have a cold sore on the lip. It was as if I was terrified because of something" (T4-Intw). In

another session, she indicated: “I felt as if falling down from the sky while the patient was talking about emptiness (T4-D).

3.4 Working with Somatic Countertransference

Therapists mentioned various reactions to sensations that they noticed and there were different ways of working with them. For many of the participants the main question that arose was related to the source of sensation. Many of them described an effort to understand who the sensation belonged to, what was its sources. Another reaction was closing off the body when a sensation appeared. On the other hand, staying with such sensations and reflecting on them were also mentioned. Additionally, regulating was also another reaction of therapists.

3.4.1 The Body as a Guide

Many participants in the study stated that they used the body as an organ of information in the process an attended to stories of body to facilitate their therapeutic work. Sensations were considered as signals that body sent to communicate them about what is going on: “It is like a signal” (T4-Intw). Similarly, another therapist mentioned: “A signal body is sending to me, a symbol” (T6-Intw).

Body appeared as a tool guiding therapist in sessions: “It provides so many clues, so many things that we can use as a tool” (T5-Intw). One them also indicated: “I was able to feel that something important is going on in my body as well so it was like a guide for me” (T7-Intw). This therapist also mentioned how

body facilitated her work: “It seems as if the flow in my body was telling me that my mind can also flow. In a sense my body guided me and facilitated my work” (T7-D).

Sensations were guidance tools for therapists in order to grasp what is going on. Accordingly, a therapist emphasized the role of body as a guide: “This sensation seems familiar but disturbing. Maybe it is better than having no sensation at all because I don’t understand when there is no sensation, I don’t understand what is going on” (T1-D). For some participants, it seems that the body led the way and without its guidance it was difficult to find the way.

Body seemed to be used by therapists as a guide in terms of therapeutic relationship and the process well. A therapist stated: “These sensations enabled me to live what is happening within the patient both in the sessions and in general, what is happening between us in the room not only mentally but more on an experiential level” (T7-Intw). Another therapist explained how she noticed what is going on in the relationship with the help of her sensations:

> I remember I thought that I had never realized this before with this patient, how on earth I took the bait? I realize this now so I will stand firm. My inner feeling, I mean my bodily sensation enabled me to realize something that I had been fooled about and in a different level, I said to myself: ‘wait a minute, I have to stop, I will not give what he demands right now’. This was something different coming from my body and something that I have not noticed before these notes (T1-Intw).

Monitoring sensations enabled therapists to monitor process as well. A therapist mentioned:

> I remembered my experience such as boredom and sleepiness and I realized this is indeed what she was doing to me. Actually, if I did not

> monitor my sleepiness, if I did not pay attention to that maybe her interpretation would sound something that she said related to her inner world. I could interpret each session as she invalidated it or tried to move away etc. But, I was able to interpret this as you are doing the same to this field, to this relationship (T5-Intw).

Attending to body also offered an opportunity to grasp disregarded aspects of relationship in the room. Also, another therapist noted:

> I have a very problematic relationship with one of them. Realizing these sensations, I mean I used to think I was not angry after sessions or in sessions but looking at those sensations I said 'no, I am quite angry or I am going through something inside of me. It enabled me to see these (T6-Intw).

Furthermore, emerging content in a session seemed to be experienced firstly by the therapist on a bodily level and somehow body guided them about the emergent content. A therapist stated: "I felt an uneasiness in the left part of my head, I did not understand what happened and later in that session I learnt that he hit his head" (T2-Intw). Also; while listening to a content that seemed very trivial, another therapist could not understand the reason why that story made her feel sad: "I felt sad somehow for no reason, my eyes filled with water and I could not make sense of it" and this sensation remained as a question until later in that session when the patient remembered a similar experience which was very saddening for her (T4-D). Similarly, another therapist stated how she had a terrible gas pain in a session without a clue about what is going on and then suddenly just before leaving the room the patient told a story about being unable to make one's toilet: "For example, I did not tell him that I feel something in my stomach, I did not ask what happened. He suddenly told this"

(T1-Intw). It seems that sometimes the body communicates a story before the patient explicitly shares it.

3.4.2 The Effort to Distinguish the Source

Many participants expressed their effort to understand the origin of the aroused sensations. The main question for them was: “What is happening, is this me is this the other? Where is the other?” (T6-Intw). A therapist also commented on the same experience: “Sometimes I really thought a lot whether this is a feeling that patient evoke in me, I mean whether this is related to what happened in the session or is this my body’s reaction to me” (T1-Intw). It was experienced as difficult to name the source: “While I was writing diaries especially with Patient A, it was a process that I could not know whether this is Patient A and me or me or him, a process I really remained in limbo” (T6-Intw).

It was suggested that monitoring sensations for a while would be helpful to identify the origin: “Maybe let’s say I was really tired that day and so I may be sleepy but if I am not sleepy with another patient while I am sleepy with her, one should monitor this in order to distinguish it” (T5-Intw). Similarly, another therapist stated: “One should wait to distinguish it” (T1-Intw). Moreover, experience regarding bodily sensations was considered as an important factor to distinguishing the source: “When one does not pay attention particularly, it might go unnoticed especially when it is not that prominent. I mean distinguishing whether this is related to the patient or related to you requires experience” (T4-Intw).

3.4.3 Closing off the Body

Openness to bodily experiences is a previously discussed theme regarding the emergence of sensations in the therapy room in the first place. When therapists open their body to experience and sensations emerge, taking a step back from sensations or even closing off the body afterwards seems to be another dimension. In this direction, while listening a disgusting content a therapist expressed: "I felt that I was closing off my body" (T4-D). Similarly, another therapist wrote: "I am closing off, my body is closing off. A need for protection, closing off" and "Difficulty to tolerate pain, can be related to patients not being able to tolerate any difficulty. I can't bear, tolerate" (T1-D).

Moreover, as mentioned before a therapist (T2) described how she thinks that her body closed off most of the time as she believes she is easily affected by emotions of other people. Similarly, another therapist stated: "I thought I could not cope with them especially at first, they were too much for me" (T6-Intw). Bodily experiences somehow regarded as intense experiences and participants tended to run away from such experiences:

> I tried to invite her to a more rational level because I did not like that feeling. Feeling as if delivering a baby was not a feeling that I enjoyed, it was painful. So, I tried to invite patient to a rational level so that I can run away from such sensation (T3-Intw).

Intense and overwhelming bodily experiences seemed to be undesirable. Similarly, a therapist commented: "I realized that I have a tendency to do the opposite so as to take a step back from an experience which is too intense, too overwhelming for me" (T5-Intw). Body gets disconnected in a sense when sensations are experienced as if too much: "I can say that stiffness in muscles, headache was sometimes so intense that this feeling led to disconnection in the

body. It was as if I did not feel anything" (T7-Intw). So, sometimes in the process, participants closed off their bodies when sensations emerged as they were most too much to bear.

3.4.4 Staying with and Reflecting on Sensations

Other reactions of therapists were dwelling on sensations and reflecting on them. One of them mentioned: "Letting my internal processes to continue, I make interpretations based on combination of what he was telling me and my internal feelings" (T1-Intw). They seemed to take their time to understand what is going on: "I noticed that I was sitting slouching, but I did not hurry to change my position" (T2-D). That therapist also stated: "I monitored, mostly I monitored but I think I monitored my thoughts more" (T2-Intw). Especially when body communicated the feeling of something important was going on, therapists seem to stay with the sensations to explore their possible meanings.

> My eyes filling with tears and sensation of almost crying which I felt especially in my face area gave me relief particularly with this patient because I feel that we reach something genuine without feeling of being stuck that intellectualization bring about. I feel as if we are both genuine in the room. So, I did not try to make my sensation go away, I dwelled on the genuineness and flow of this sensation. When she began to intellectualize, I tried to stay there and focus on pain and sorrow by utilizing this sensation (T7-D).

On the other hand, for some therapists the worry about missing the verbal flow seemed to lead to sensations to be ignored at that moment. A therapist noted:

> I might not think that I should think about the possible meanings of this bodily experience. I mean, I noticed them but I think I proceeded without dwelling on them much so as to deal with them later. Because at that moment I don't know whether I was worried about missing the flow when my attention shifted to sensation. Well, mostly I wrote down that bodily experience to make sense of it later (T4-Intw).

3.4.5 Regulating

Many therapists in the study also mentioned how they soothed intense bodily experiences. Some of them used body and especially breath to reduce the intensity of the experience: "Sometimes when I felt really sleepy because of what the patient is telling me, and I felt as if I cannot endure till the end of session; then I took deep breaths to make that sleepiness go away" (T4-Intw). Making a sensation go away was important and deep breath and relaxed body was helpful:

> I was feeling a bit tense and I felt that muscles in my legs were tight. Then I changed the position of my legs, I sat back and that change in my body made me calmer. Taking a deep breath for instance, without being noticed, I realized taking a deep breath made me calmer as well (T5-Intw).

Moreover, noticing sensations were helpful to notice a disregarded emotion which was at the core of the therapeutic work. A therapist explained her experience of being verbally attacked in a session: "When I noticed that I got angry indeed, I soothed myself, I really calmed down and I really managed to handle that session" (T6-Intw).

On the other hand, verbalizing such sensations in the process, writing them on diaries was helpful to reduce intensity: "Talking about these experiences, articulating them, expressing them in words and in fact making sense of them reduced the intensity of the experience for me" (T7-Intw). Furthermore, including patient into this verbalization act through interpretations also reduced the intensity: "Tightness in my chest, anger and feelings of tension were relieved after working together on my interpretation" (T2-D). Somehow verbal activity, and reflecting on sensations –as mentioned above- was helpful for the therapist to regulate an overwhelming sensation: "That theme was too much for me at first and made me feel nauseous but then it turned into a feeling of relief as the patient proceeded by following her associations" (T6-D).

3.5 Getting in Touch

One of the main objectives of this study was to make room for body in therapeutic encounter and thus, to encourage therapists to attend to their bodies and reflect on them. Hence, the primary aim of this study was not merely reporting therapists' bodily sensations in sessions. Instead, it was intended to urge them to include their bodies in sessions even for a limited time period and observe the change accordingly, if there is any. Therefore, the narrative in this dissertation reflects not only therapists's experiences as they are without any intervention but it also portrays the effect of the present study on participants and their professional work.

All participants in the study mentioned that they attended their bodies for the first time in sessions thanks to this study. Hence, in the present study it was possible to monitor therapists' experiences of somatic countertransference as well as any change in their therapeutic work related to the body. It was

remarkable to observe the change in their connection to their bodies over time in the process; not only on a professional level but also on a personal level. It was observed that narrative account of bodily experiences became elaborated and varied with time in the 8-week research process. A therapist mentioned that she became able to realize more sessions as she trusted in body more and more in time during research process.

In this sense, getting in touch was regarded by all participants as a gain of 8-week period of attending body and journaling in the process of study. Thus, this theme unlike previous themes, which depicted participants' subjective experiences in the process, portrays the gain of attending to body in sessions as a result of participation to the present study.

Getting in touch emerged in two ways: therapists' getting in touch with their bodies, getting in touch with patient. At the end of this process, therapists mentioned that they realized how they came into contact with their own bodies and how they became engaged in patients' experience and deepened their relationship with patient as well.

3.5.1 Getting in Touch with Body

All participants commented on their experience of getting in touch with body. Some of them also indicated that they become much more engaged in their body not only in the therapy room but also in their personal lives.

Attending to body in the research process was considered as adopting a new perspective that one did not even think of before. For instance, a therapist compared her experience in the process to "a camera looking inside through itself" and further noted:

> What is going on in my body is an aspect that I never think of. Thank you for making me, a person who never attends to her body, to attend to my body. Once you open that new window, you gave me that perspective, I think that will come automatically from now on (T3-Intw).

Similarly, another therapist expressed her experience in the process: "Working a muscle I do not usually work, it is like an opportunity work it" and further stated: "Maybe I had sensations before as well, but I might miss them while focusing on the verbal content. When I specifically focused on this aspect, I got in touch with my body better" (T4-Intw). Attending to the body was experienced as if capturing something that went unnoticed. One of them also indicated: "We have done only a very little example. But even this made me notice the sensations different than usual, maybe even those I would never notice" (T7-Intw). A therapist also mentioned how she noticed a previously disregarded feeling of anger with the help of her sensations:

> Suddenly I noticed first my hands were sweaty and then my heart started to palpitate. Apart from analysis and supervision, I think I could notice this at that moment thanks to this diary. Because, generally I do not pay attention to signals of body; moreover, I am not even aware of them (T6-D).

Moreover, aside from capturing the unnoticed experiences; paying a particular attention to body provided an opportunity of meaning making of previously felt sensations: "Getting bored, sleepiness etc. they all happened before. But I did not know their location on the map. Now it is like pinpointing. It became clear like how, then, when the patient say this" (T2-Intw).

A therapist who previously defined mind as a safe space commented on body: “I experienced it not as insecure as I thought before” (T5-Intw). In terms of her experience in the process she also explained:

> It enabled me to realize: in what conditions I become nervous, what kind of interpretations I made causes my body to react more, in what conditions I become sleepy more etc. It made me see the whole picture. It may provide even more clues about both individuals’ own subjectivity and about their professional identity as a therapist as well as therapists’ stance (T5-Intw).

Similarly, some of them also commented on reflections of this process in personal level. A therapist stated:

> We are only talking about sessions, but I believe that attending to these sensations can also be transferred to out of the therapy room. I mean, if you get in touch once, even a little bit, it seems as if it can be expanded and opened as you get in touch. In that sense, I think this also a cue for life as well (T7-Intw).

Another one indicated:

> It made me pay attention, look at it. I mean, I also begin to examine my body in outside of this research process as well. For instance, why do I slouch all the time? I think it enabled me to see my body (T6-Intw).

3.5.2 Getting in Touch with Patient

Many participants mentioned that attending to body also provided an opportunity to get in touch with patients and their lived experiences. A therapist indicated:

> Since she has a problem mainly with her body, I felt as if those sensations that I noticed in my body after I begin attending to were helpful for understanding her. I felt that I could utilize them, I could understand her pain (T6-Intw).

Sensations were considered as a way to understand patients' experience at first hand:

> It makes you feel close to the patient. Oh hunger! Everyone knows how hunger feels like or fear of hunger, especially if it is an intense sensation. So this is how you feel, you feel hungry this much, as if you cannot survive even thirty seconds. I see, this is what you are telling me (T4-Intw).

Another therapist also indicated: "I think that was a communication between us, as if telling patient that I understood how terribly frightened you feel (T4-Intw). It was as if patients were telling how they feel by making therapists experience their experiences at first hand: "She was making me experience the terror that she experiences, and I think this was a cue about how the patient experiences such terror" (T7-Intw).

It was also mentioned that understanding such experiences at first hand enables establishing a connection with the patient: "A beautiful connection that cannot be achieved otherwise is established when you get in touch and if it is understood correctly" (T4-Intw).

It seemed therapists and patient meet somehow on a common ground without words:

> I think there was a harmony between us. Sometimes, well, I thought maybe I could make sense of what is going on without speaking. I mean, it was as if being in communication with patient even if we did not speak, staying in communication through bodies without even verbalizing (T6-Intw).

Moreover, such connection was also symbiotic for some therapists:

> I think the issue regarding being heard can be an experience like that. Don't look at surroundings, just look at me. Even it is like a baby who does not see surroundings and barely recognizes mother's face only if she is close enough. It might even refer to a longing related to that relationship. It is a relationship which is too symbiotic but very intimate and real and nurturing (T5-Intw).

Another therapist also stated that "something that is symbiotic-like happens in such moments" (T3-Intw). Such moments were experienced as a merge between therapists and patient and the boundary of 'me and the other' were experienced as blurred. Accordingly, this experience of knowing from the inside was also regarded as something magical:

> Sometimes he said 'how do you know, how do you understand these?'. It is difficult to explain this for sure. Because you perceive something which he did not tell you with words and in that case, your understanding is felt like magic, like fortune teller. He feels as if I am looking to an invisible magic ball and telling him. So, he was wide-eyed while he was saying: 'How do you know these, how?'. Sometimes his eyes filled with tears, I mean being understood that much. Because this is not being seen, not

> being heard since it is not something he said, this is being felt. And this sense of being felt touches somewhere deep inside of patient. I mean because you feel something beyond words in your body, you feel something that was maybe never expressed in words (T1-Intw).

Similarly, another therapist also commented on this magical aspect: "These sensations represent a magical moment for me. Feeling these sensations make me feel that I can unveil her inner world and that I reach something genuine" (T7-D). It seemed that there were such moments of deep connection in which therapist unveiled something similar to children who cannot lie to their mother since she knows the inside: "On the other hand, there may be time that he gets upset because I begin to notice many other things that he has been hiding for all this time" (T1-Intw).

On the other hand, attending to the body not only enables understanding patients' experience at first hand but also enables working with patients' affective experience. It provides a container for the patient's feelings. A therapist noted: "While talking about solely thoughts, towards to end of the session she started talking about what she was feeling. I mean, she also became able to reach her emotions as well rather than solely her thoughts" (T5-Intw). Another therapist also pointed out:

> I felt as if we were talking about genuine feelings. For instance, we were talking about a memory which was too ambivalent and after a while patient's feelings became so intense that he felt in a sense a safe space for a moment and I think there was a moment he said that 'I can feel sad here' and this is a very big step for him. Being able to feel sad in here, in therapy room (T7-Intw).

DISCUSSION

The main purposes of this study were to provide an account of therapists' reported bodily sensations in countertransference; to understand how therapists experience and make use of these bodily sensations in psychotherapy and how therapist's clinical attention on these bodily sensations affect their experiences in the psychotherapy process over time. In doing so, it was intended to contribute to an understudied aspect of countertransference in both literature and clinical practice. In this sense, five main themes were revealed in the study and they shed light on how the body is perceived in the therapy room, factors in terms of bringing body into the room, therapist's reactions to bodily experiences and the perceived therapeutic effect of attending to body in the sessions. Moreover, with a diary method, the present study was able to capture therapists' immediate experiences of the body in the therapy room.

The most prominent gain of the present study perhaps is that it provided a space to reflect on body in sessions even for a limited period of time. It was striking that all participants in the study reported attending to their body in the sessions for the very first time as a result of participating in this study. Even though they were engaged in their bodies on a personal level, body was left out of the therapy room. Thus, this study contributes to discussion of what brings body to the therapy room and what hinders it from coming as well as the question of how it comes into play.

Findings suggest that somatic countertransference appeared as a method of communication between the patient and the therapist. It was as if patients were telling their stories by making therapists experience them at first hand; namely penetrating the skin of therapist. These experiences appeared in various forms: Sometimes, a feeling that cannot be tolerated by patients appeared in the body of

therapists; sometimes patients' traumatic memories yet to be articulated firstly experienced bodily by therapists (T1, T2, T4). In other times, complementary somatic countertransference as mentioned by Dosamantes-Alperson (1987) by reflecting on Racker's (1968) idea of complementary and concordant psychotherapists was observed in various forms such as therapist's feeling of drained mother in the face of patient's greed (T4), therapists' slouch sitting in accordance with theme of power dynamics (T2, T3) and so on. In all cases, it seems that therapists' bodies become an area that patients' stories are experienced. This aspect of somatic countertransference echoes Bion's (1959) ideas regarding the alpha function of the mother; a container. It appears as if patients utilize therapists' bodies as a container to not only tell their experience but also to investigate their unbearable experiences in a body that contain them (Bion, 1959). In that sense, opening the body to an experience also refers to offering body as a container of intolerable experiences. Therapists' bodies become an area to experience what patients evoke in them and then process such material of patient and give them back to the patient in a new, transformed form that the patient can contain. However, the question is how safe therapists feel in terms of offering their body as a container just like they offer their psyche (Orbach, 2003).

Keeping that question in mind, it should be also noted that one of the primary findings of this study is that the question of ownership of bodily experiences was an issue that became significant for therapists. This finding is in line with the existing literature as well as findings of Athanasiadou and Halewood's research (2011). There was an effort in terms of distinguishing the owner; the origin of sensations. Moreover, the meaning making process regarding this issue was only speculative; no participant was certain about the source. Yet, it was obvious that they were puzzled with such question and it was as if impossible to differentiate the owner. It seems that bodily sensations were

experienced as moments where the clear distinction between me and the other is blurred; after all, they feel them under their skin. Thus, sensations were experienced in therapists' part as a merge between patients and therapists; or in other words as an immersion to patients' inner world. It was as if a symbiotic moment between them (T3, T5). It was so intense, so symbiotic that sometimes therapists experienced their patients experience or in other words they knew their experiences 'inside' out. There seems a moment that therapists and patients meet and become very close when therapists body becomes a container.

In a sense, therapists' such experience of immersion resembles, in therapists' part, what The Boston Change Process Study Group (BCPSG) called "moments of meeting" (Stern, 1998, p. 300). When therapists and patients are "moving along", some "now moments" which convey a nonverbal affective expression. When these interactive moments are attended to "they tell us about the patient's implicit relational knowing about his relationship with the therapist and vice versa" and this kind of knowing also is what Bollas (1987) implied with the term "unthought known" (Stern, 1998, p. 304). This therapeutic attention to now moments and the mutual recognition of such moments by the therapeutic dyad leads to moments of meeting (Stern, 1998). According to Stern, for these moments to occur therapists' embodied presence is crucial. In the present study, therapists articulated how they experienced such experiential way of knowing and how this is felt by the patients as well. According to them, they meet with patients on the same boat, which might be considered as therapists' body becoming a container, and feeling how the patients feel. Thus, attending to body appears to provide a way for relational knowing (Rappoport, 2012). Also, this experiential knowing facilitates an affective meeting moment in therapeutic relationship and it enables patient to be heard and understood and moreover as T1 suggested "to be felt" (Divino & Moore, 2010). Moreover, it also seems to influence the quality of therapeutic relationship. Many therapists in the study

depicted the outcome of attending to bodily sensations in sessions as a "genuine" and "deeper" relationship, and "a beatiful connection", and it was even magical. Sensations, when they are attended to, seem to provide a special way of knowing and relating "that cannot be established otherwise" (T4).

However, attending to bodily sensations was sometimes experienced as a difficult task. In accordance with this, the concept of neglected body was prominent in the study. It was somehow difficult to bring the body into the room and even if the primary purpose of this study process was to make therapists attend to their bodies, it was frequently forgotten. At this point, the main question is: How can individuals forget the body that they dwell in? In the study, body was mentioned as if it is separate from mind. This perception of body in the study echoes Cartesian understanding of mind-body distinction (Wiener, 1994). Even though therapists put an effort to include their bodies in the therapeutic work, it was overshadowed by verbal activity in sessions. The core of therapeutic technique was verbal exchange and body was brought in as complementary. Thus, whenever they noticed that they shifted their focus from verbal activity to body, they felt nervous about missing some important aspects of sessions which communicated verbally. This is not shocking indeed, what we are doing has conventionally been regarded as a talking cure after all.

However, what was surprising is that there was a prominent fear regarding body in therapy room. Body appeared as a frightening place that one naturally wants to get into. This finding was in line with ideas of Miller (2000), who drew attention to therapists' fear of body. According to Miller (2000), fear of body can be grouped as "losing control, not knowing, and losing face" (p. 442). Similarly, in the study, the fear of getting lost (T5) was mentioned in relation to fear of body. Body appeared as a frightening territory that no one knows their way around. Also, in accordance with Miller's (2000) ideas, fear related to this

unknown aspect of body was also apparent in findings. This obscure territory could reveal something that is perhaps very intimate. Therapists (T5, T6) expressed their uneasiness as if revealing something very intimate and thus being exposed. Thus, fear of body in relation to loss of face was consistent with such idea. Body was so obscure and uncanny that therapists often sheltered in the safe and familiar space of words and mind. After all, individuals can control what they say, however; it seems as if they do not have control over the emergence of their bodily sensations. Body is full of surprises and it takes courage to embrace such unexpectedness in therapeutic encounter.

At this point, openness to such experiences is an important aspect of bringing body to room. King (2011) also referred to openness to bodily experiences in terms of therapists' receptivity of bodily cues. Also, in the study some therapists could attend to their bodily experiences more easily than the others. They stayed with sensations, took their time to understand quality and possible meanings of sensations. They made use of their sensations to understand patient and therapeutic relationship. Some of them utilized their bodies to understand their own affective state and thus made use of sensations and their bodies as tools for regulate themselves. Namely, they could dare to get into an unknown territory without thinking of possible downsides; getting lost, touching to an unknown and intimate part in psyche. Hence, leaving the safe area of mind was experienced as though leaving comforting sense of familiarity as well. Going back to aforementioned experience of relational knowing through moments of meeting, such experience of breaking routine of therapeutic technique resembles Stern's (1998) comments: Due to the unpredictable nature of now moments both patients and therapists feel surprised with a "sense of taken off guard" since this experience refers "nonlinear jump" out of habitual and there is no way to be prepared for such experience in advance since no one can know exactly what is waiting there (p. 304). In line with this, in the study it

seems that some therapists are mostly disconnected from their bodies and one of them even emphasized being caught off guard by sensations that other people evoke while another one mentioned bodily resistance in terms of including body as a novel perspective to therapeutic techniques.

Moreover, according to DeYoung, Grazioplene and Peterson (2012), openness enables one to engage "primarily with perceptual or sensory information" (p. 64). On the other hand, they also suggested that increasing the sensitivity to such information also "increases the range of stimuli available to worry about" (DeYoung, Grazioplene & Peterson, 2012, p. 76). Thus, it seems that opening oneself to bodily experiences leads too much material to be available to process. Moreover, findings suggest that one of the important factors in terms of emergence of sensations is therapists' own subjectivity. In addition to this, as somatic countertransference is considered as a co-created product of two members (Rappoport, 2012), it can be inferred that body opens a door not only for patients' psyche but also for therapists' own psyche (Schore, 2014). Consequently, this psychic material sometimes can be experienced as if it was too much to bear (T5, T6). Similarly, Athanasiadou and Halewood (2011) emphasized disconnection and resistance in terms of sensations in countertransference in their study. It was also remarked that therapists may defend themselves against bodily experience (Athanasiadou & Halewood, 2011). Similarly, one of the reactions of therapists in the study was to close off their bodies especially when the experience was so intense. Also, Shaw (2003) pointed out how therapists close off their bodies in the face of an intense experience.

So far, the issue of including body into the sphere of clinical attention seems to be associated with the extent that therapist can attune to changes in the interactive affective moments of encounter and their capacity to contain affective

experiences. Bion (1962) emphasized mothers' capacity of "reverie" in terms of alpha function (p. 36). Capacity of reverie was considered as "a capacity for thought as a means of softening frustration" (Bion, 1962, p. 37). Further, Ogden (1997a) elaborated the nature of reverie, also including bodily sensations, as intense affective experiences that is communicated not verbally but known through what is thought and felt. Moreover, according to him "our use of our reveries requires tolerance of the experience of being adrift" (Ogden, 1997a, p. 569). Thus, reverie as primary factor of containment requires willingness to explore beyond the familiar and which is "almost always unanticipated" (Ogden, 1997a, p. 569). Similarly, findings show that opening body for exploration without resisting it, even further dwelling in sensations, reflecting on them without defending against them seems to function as a deepening tool in therapeutic relationship. Containing function of body requires allowing exploratory quest (T5). Moreover, exploring bodily sensations through reverie, therapists' coming to senses, enables "patient's developing capacity to come to his senses" (Ogden, 2001, p. 100). Similarly, therapists in the study stated that reflecting on sensations, allowing them to emerge and express themselves are enriching (T7). Some therapists also talk about these sensations as guiding them in the right direction, helping them clarify the real dynamics which can be blurred by defenses, providing a more 'genuine' understanding as well as a more genuine relationship.

Plus, reflecting on sensations also can be regarded as minding the body; it suggests unity of mind and body. Participants reported how reflecting on them even sometimes articulating them soothed their intense sensations (T2, T7) and on the other hand, they also stated that they sometimes realized their feelings and state of mind via bodily sensations (T5, T6) how they regulate themselves through body (T5, T6). It seemed that for those therapists who could stay with

their bodily sensations and reflect on them body and mind were not experienced as competing entities but could coexist in a flow. (T7).

On the other hand, it can be concluded that words alone, despite being a safe space for therapists, were considered as limited in terms of communicating the lived experience. As mentioned in the literature, many participants in this study described a gap between the lived experience and verbal expression of such experience (Pally, 2001; Stern, 1985). Thus, experiences expressed in the study were somehow referring to the feeling of experience that might be experienced by the other as well (T4). Moreover, verbal expressions also included bodily experiences. As expected, everyday phrases in our languages reflect our embodied intersubjective existence (Ross, 200). Similarly, Lakoff and Johnson (1980) commented on this embodiment of everyday metaphors: "since our brains are embodied, our metaphors will reflect our commonplace experiences in the world" (p. 257). Furthermore, body was experienced as if it was speaking. This interchange between body and words might be related to apparent competition between mind and body; one is dominating the other. However, it should be also considered that this coexistence of bodily experiences and words also indicates an ignored mind-body unity indeed. Mind and body already exist in unison; they come to sessions in a body. The only thing that we need to do is to embrace such unison.

4.1 Clinical Implications

As Aron (1998) proposed, what we gather about patient as well as therapeutic relationship including our subjectivity seems to be felt in our bodies. Plus, it seems that attending to body enables a way of affective experiential

knowing in therapy. Therapists' "empathic immersion into" the patients' experiences via their bodies provides an in-depth empathic understanding of how it feels to be that patient and this understanding seems to be communicated somehow and enable patient to be felt (Gotthold & Sorter, 2006, p. 112). Moreover, attending to bodily sensations in sessions, in other words, shifting focus from an intellectual level to more of an experiential affective level seems to enable a similar shift in the patient and thus working with patients' affective experience as well.

Therapists' bodies not only they provide significant cues in terms of what is going on in patient, in relationship as well as in therapists but also, they create a safe space, a container where intolerable experiences can be experienced and digested. Echoing Bion (1959) and Orbach (2006), it can be said that therapists' offering their bodies for patients provides a kind of a practicing area for their overwhelming experiences until they have a body on their own. Yet, providing such practicing area for patients seems to lead such a shared intense affective moment that boundaires of self and other sometimes may become somewhat transparent. Hence, this intense experience seems to raise some questions for therapists regarding to source of their bodily sensations. In the present study, bodily sensations were mostly considered as something that patients evoked in therapists. However, the way that such evoked sensations manifested in therapist bodies was considered by participants as directly related to their own subjectivities. But at first, all of them puzzled with such question of ownership and perhaps; this questioning, this investigation itself is one of the most important components of working with bodily sensations in therapy. In doing so, therapists might attend to and follow such sensations to unexplored territories in therapy.

Namely, with the use of reverie, therapists can explore an unknown territory in therapeutic encounter with their bodies. Moreover, Ogden (1997b)

emphasized metaphor in relation to reverie. In utilization of reverie in therapy, there is an aspect that we re-present unconscious materials as verbal metaphors (Ogden, 1997b). He remarked that dreams, reveries and symptoms they are all "metaphors for the individual's unconscious experience" (Ogden, 1997b, p. 728). Taking this idea one step further, we can propose that body is a metaphor. It should be attended to and followed to new therapeutic territories to discover meeting moments in the encounter. We should make room for it, surrender ourselves to its meanings.

Yet, the question is: How can therapists surrender themselves to bodily experiences in sessions if body remains such an unknown territory that frightens people about what could happen to them if they involved? One, in all conscience, can claim that these experiences are unanticipated in nature, also in light of aforementioned literature. Yet, are not all therapeutic encounters inherit such nature? So, how can body be the most frightening one among all other unpredictable aspects of therapeutic encounter? There should be something specific to body as discussed before. Hence, firstly we need to remind ourselves the body both in clinical practice and in relevant literature (Ogden, 2001).

The question regarding the extent of visibility of such bodily experiences in therapy sessions may still remain a taboo for many psychoanalytic therapists who conventionally adopted abstinence. Yet, from a contemporary point of view, perhaps we should be able to discuss expressing and disclosing our bodily sensations when it is appropriate for the benefit of therapeutic process, just like countertranference 'feelings'. Yet, even if they are not disclosed, it is clear bodily sensations should be attended to and included in session notes to monitor flow of relational process via sensations. Supervisions also should include bodily aspects of countertransference as well. In this sense, Sletvold (2016) proposed an embodied form of supervision, in which supervisees were asked to physically recreate sessions in supervision. He emphasized this kind of supervision is

intriguing since it enables therapists to reach many hidden aspects of therapeutic encounter. Similarly, Divino and Moore (2010) included body in the curriculum of their course and asked students to attend to their bodily sensations in sessions and take detailed notes about them to later discuss with supervisors. A similar approach should be adopted in many other graduate programs as well. The more the importance of nonverbal interaction and body is taught, the more bodily aware clinicians we will have and maybe, eventually, it will be possible, at least to some extent, to overcome the fear of body in therapy room. Accordingly, more research studies regarding body in psychoanalytic practice are required; we should investigate body and hear its stories. In this way, we can make the body known and embraced.

4.2 Limitations and Future Study

Although some strategies were employed to ensure trustworthiness in the study, this research reflects a subjective stance in nature. In that sense, sample size was appropriate and deliberately chosen to be small in accordance with the idiographic nature of IPA. However, it should be born in mind that these findings might not be generalizable. Additionally, participants who volunteered in this study were only females, although it was not a deliberate choice, since only those who volunteered to participate was included; therefore, it was not possible to give voice to male therapists' experiences and thus, it is not known whether there would be any difference in terms of sex of participants.

In the present study, only psychoanalytic oriented psychotherapists were included to achieve homogeneity and in order to make sure participants are familiar with monitoring and working countertransference feelings; so, body was

to be included an existing therapeutic work of countertransference. However, it is believed that bodily countertransference is both a common experience and an important tool in psychotherapy regardless of professional orientation (Shaw, 2004). A future study may intend to understand how therapists from diverse range of psychotherapy schools experience their body in psychotherapeutic process and make use of it by utilizing a journal keeping method.

Moreover, this study was only able to examine therapists' experiences and it is not clearly known how patients experienced such process of therapists' attending to their bodies. Our knowledge regarding patients is only limited with the therapists' limited narratives. A future study can investigate such process including patients' experiences as well. This study also captured only a limited time in therapeutic process, a future study can further investigate bodily experiences of therapeutic dyad for a longer period.

Furthermore, our knowledge of patients' psychodynamics is also quite limited due to ethical reasons. Thus, although it is believed that nonverbal communication is a part of basic human interaction, we cannot draw a conclusion about how bodily sensations differs based on specific patients' characteristics and moreover based on different patients-therapists matches. Moreover, openness to bodily experience was an important finding in terms of including body in therapeutic work, a future study can also investigate whether therapists' personality characteristics, especially openness to experience, influence bodily experiences in therapy. In doing so, we can differentiate a possible difference between openness to experience and fear of body.

References

Athanasiadou, C., & Halewood, A. (2011). A grounded theory exploration of therapists' experiences of somatic phenomena in the countertransference. *European Journal of Psychotherapy & Counselling*, *13*(3), 247–262. https://doi.org/10.1080/13642537.2011.596724

Aron, L. (1998). The clinical body and the reflexive mind. In L. Aron, & F. S. Anderson (Eds.), *Relational perspectives on the body* (pp. 3–38). Hillsdale, NJ: The Analytic Press.

Balint, M. (1949). Changing therapeutical aims and techniques in psycho-analysis. *The International Journal of Psycho-Analysis*, *31*, 117-124.

Beebe, B. & Lachmann, F. M. (2002). Organizing Principles of Interaction from Infant Research and the Lifespan Prediction of Attachment: Application to Adult Treatment. *Journal of Infant, Child, and Adolescent Psychotherapy*, *2*(4), 61–89. https://doi.org/10.1080/15289168.2002.10486420

Benjamin, J. (2004). Beyond Doer and Done to: An Intersubjective View of Thirdness. *The Psychoanalytic Quarterly*, *LXXIII*(1), 5–46. https://doi.org/10.1002/j.2167-4086.2004.tb00151.x

Bion, W. R. (1959). Attacks on Linking. *The International Journal of Psycho-Analysis*, *40*, 308–315.

Bion, W. R. (1962). Learning from Experience. London: Heinemann.

Bion, W. R. (1963). Elements of Psychoanalysis. London: Heinemann.

Bloom, K. (2006). *The embodied self: movement and psychoanalysis*. London; New York: Karnac.

Bollas, C. (1987). *The shadow of the object: psychoanalysis of the unthought known*. London: Free Association Books.

Egan, J., & Carr, A. (2008). Body-centred countertransference in female trauma therapists. *Irish Association of Counselling and Psychotherapy Quarterly Journal, 8*, 24-27.

Egan, J., Booth, A., & Trimble, T. (2010). Feeling it: body-centred counter-transference in a sample of Irish clinical psychologists. *Irish Psychologist.*

DeYoung, C. G., Grazioplene, R. G., & Peterson, J. B. (2012). From madness to genius: The Openness/Intellect trait domain as a paradoxical simplex. *Journal of Research in Personality*, *46*(1), 63–78. https://doi.org/10.1016/j.jrp.2011.12.003

Diamond, N. (2001). Towards an interpersonal understanding of bodily experience. *Psychodynamic Counselling*, *7*(1), 41–62.

Divino, C. L., & Moore, M. S. (2010). Integrating Neurobiological Findings into Psychodynamic Psychotherapy Training and Practice. *Psychoanalytic Dialogues*, *20*(3), 337–355. https://doi.org/10.1080/10481885.2010.481613

Dosamantes-Alperson, E. (1987). Transference and countertransference issues in movement psychotherapy. *The Arts in Psychotherapy*, *14*, 209–214.

Dosamantes-Beaudry, I. (1997). Somatic experience in psychoanalysis. *Psychoanalytic Psychology*, *14*(4), 517–530. https://doi.org/10.1037/h0079738

Ferrari, A. B. (2004). *From the Eclipse of the Body to the Dawn of Thought*. London: Free Association Books.

Field, N. (1989). Listening with the Body: An Exploration in the Countertransference. *British Journal of Psychotherapy*, *5*(4), 512–522. https://doi.org/10.1111/j.1752-0118.1989.tb01110.x

Finlay, L. (2006). The body's disclosure in phenomenological research. *Qualitative Research in Psychology*, *3*(1), 19–30. https://doi.org/10.1191/1478088706qp051oa

Forester, C. (2007). Your own body of wisdom: Recognizing and working with somatic countertransference with dissociative and traumatized patients. *Body, Movement and Dance in Psychotherapy*, *2*(2), 123–133. https://doi.org/10.1080/17432970701374510

Freud, S. (1955). *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (J. Strachey, Trans.). London: Hogarth Press.

Fries, E. F. (2012). Perchance to sleep: Minding the unworded body in psychoanalysis. *Psychoanalytic Dialogues*, *22*(5), 586–605.

Gainotti, G. (2006). Unconscious Emotional Memories and the Right Hemisphere. In *Psychoanalysis and Neuroscience* (pp. 151–173). Springer, Milano. https://doi.org/10.1007/88-470-0550-7_6

Gallese, V., Eagle, M. N., & Migone, P. (2007). Intentional attunement: Mirror neurons and the neural underpinnings of interpersonal relations. *Journal of the American Psychoanalytic Association*, *55*(1), 131–175.

Gallese, V. (2009). Mirror neurons, embodied simulation, and the neural basis of social identification. *Psychoanalytic Dialogues*, *19*(5), 519–536. https://doi.org/10.1080/10481880903231910

Gee, P. (2011). Approach and Sensibility': A personal reflection on analysis and writing using Interpretative Phenomenological Analysis. *Qualitative*

Methods in Psychology Bulletin, *11*(1), 8–22.

Gotthold, J. J., & Sorter, D. (2006). Moments of Meeting: An Exploration of the Implicit Dimensions of Empathic Immersion in Adult and Child Treatment. *International Journal of Psychoanalytic Self Psychology*, *1*(1), 103–119. https://doi.org/10.2513/s15551024ijpsp0101_6

Greene, A. U. (2001). Conscious mind—Conscious body. *The Journal of Analytical Psychology*, *46*(4), 565–590. https://doi.org/10.1111/1465-5922.00268

Gubb, K. (2014). Craving Interpretation: A Case of Somatic Countertransference. *British Journal of Psychotherapy*, *30*(1), 51-67.

Heimann, P. (1950). On counter-transference. *The International Journal of Psychoanalysis*. *31*, 81-84.

Jacobs, T.J. (1973) Posture, gesture, and movement in the analyst: Cues to interpretation and countertransference. *Journal of the American Psychoanalytic Association 21*, 77–92.

King, A. (2011). When the body speaks: Tummy rumblings in the therapeutic encounter. *British Journal of Psychotherapy*, *27*(2), 156–174. https://doi.org/10.1111/j.1752-0118.2011.01233.x

Klein, M. (1946). Notes on Some Schizoid Mechanisms. *International Journal of Psycho-Analysis*, *27*, 99–110.

Klein, M. (1975). *Envy and Gratitude and Other Works, 1946-1963*. New York: Delacorte Press/S. Lawrence.

Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago, IL:

University of Chicago Press.

Lombardi, R. (2011). The Body, Feelings, and the Unheard Music of the Senses. *Contemporary Psychoanalysis*, *47*(1), 3–24. https://doi.org/10.1080/00107530.2011.10746439

Martini, S. (2016). Embodying analysis: the body and the therapeutic process. *Journal of Analytical Psychology*, *61*(1), 5–23. https://doi.org/10.1111/1468-5922.12192

Meissner, W.W. (2007). Mind, brain and self in psychoanalysis: Therapeutic implications of the mind-body relation. *Psychoanalytic Psychology, 24*, 333–354.

Meltzoff, A. N., & Decety, J. (2003). What imitation tells us about social cognition: A rapprochement between developmental psychology and cognitive neuroscience. *Philosophical Transactions of the Royal Society of London, Series B, 358*, 491–500.

Merleau-Ponty, M. (1964) 'The child's relations with others', in *The*

Primacy of Perception, North Western University Press.

Miller, J. a. (2000). The fear of the body in psychotherapy. *Psychodynamic Counselling*, *6*(4), 437–450. https://doi.org/10.1080/13533330050197070

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: an integration*. Cambridge, Mass: Harvard University Press.

Money-Kyrle, R. E. (1956). Normal Counter-Transference and Some of its Deviations. *International Journal of Psycho-Analysis*, *37*, 360–366.

Ogden, P., Minton, K., Pain, C., & Bhugra, D. (2006). *Trauma and the body: a sensorimotor approach to psychotherapy*. New York; London: W.W. Norton.

Ogden, T. H. (1979). On Projective Identification. *International Journal of Psycho-Analysis*, *60*, 357–373.

Ogden, T. H. (1992). *Projective identification and psychotherapeutic technique*. London: Maresfield Library : H. Karnac. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=367157

Ogden, T. H. (1994). The analytical third: working with intersubjective clinical facts. *International Journal of Psycho-Analysis*, *75*(1), 3–20.

Ogden, T. H. (1997a). Reverie and interpretation. *Psychoanalytic Quarterly*, *66*, 567–595.

Ogden, T. H. (1997b). Reverie and metaphor: Some thoughts on how I work as a psychoanalyst. *International Journal of Psychoanalysis, 78*, 719–732.

Ogden, T. H. (2001). Re-minding the body. *American Journal of Psychotherapy*, *55*(1), 92–104.

Ogden, T. H. (2004). The Analytic Third: Implications for Psychoanalytic Theory and Technique. *The Psychoanalytic Quarterly.*, 167–195.

Orbach, S. (2003). Part I: There Is No Such Thing as a Body. *British Journal of Psychotherapy*, *20*(1), 3–16. https://doi.org/10.1111/j.1752-0118.2003.tb00110.x

Orbach, S. (2004). What can we learn from the therapist's body? *Attachment & Human Development*, *6*(2), 141–150. https://doi.org/10.1080/14616730410001695349

Orbach, S. (2006). How can we have a body?: Desires and corporeality. *Studies in Gender and Sexuality*, *7*(1), 89–111.

Orbach, S., & Carroll, R. (2006). Contemporary approaches to body in psychotherapy: Two psychotherapists in dialogue. In J. Corrigall, H. Payne, & H. Wilkinson (Eds.), *About a body: Working with the embodied mind in psychotherapy* (pp. 63–82). London: Routledge.

Pally, R. (1998). Emotional Processing; The mind-body connection. *The International Journal of Psycho-Analysis, 79*(2), 349.

Pally, R. (2001). A Primary Role for Nonverbal Communication in Psychoanalysis. *Psychoanalytic Inquiry*, *21*(1), 71.

Racker, H. (1968). *Transference and counter-transference*. London: Maresfield Reprints.

Rappoport, E. (2012). Creating the Umbilical Cord: Relational Knowing and the Somatic Third. *Psychoanalytic Dialogues*, *22*(3), 375–388. https://doi.org/10.1080/10481885.2012.679607

Rizzolatti, G., Fogassi, L., & Gallese, V. (2006). Mirrors of the mind. *Scientific American*, *295*(5), 54–61.

Renik, O. (1993). Analytic Interaction: Conceptualizing Technique in Light of the Analyst's Irreducible Subjectivity. *The Psychoanalytic Quarterly*, *62*, 553–571.

Rosenfeld, H. (1952). Notes on the Psycho-Analysis of the Super-Ego Conflict of an Acute Schizophrenic Patient. *International Journal of Psycho-Analysis*, *33*, 111–131.

Ross, M. (2000). Body talk: somatic countertransference. *Psychodynamic Counselling*, *6*(4), 451–467. https://doi.org/10.1080/13533330050197089

Rumble, B. (2010). The body as hypothesis and as question: towards a concept of therapist embodiment. *Body, Movement and Dance in Psychotherapy*, *5*(2), 129–140. https://doi.org/10.1080/17432979.2010.494852

Samuels, A. (1985). Countertransference, the 'Mundus Imaginalis' and A Research Project. *Journal of Analytical Psychology*, *30*(1), 47–71. https://doi.org/10.1111/j.1465-5922.1985.00047.x

Sandler, J. (1976). Countertransference and Role-Responsiveness. *International Review of Psycho-Analysis, 3,* 43–47.

Schore, A. N. (2001). The effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 7–66.

Schore, A. N. (2007). Psychoanalytic research, progress and process: Developmental affective neuroscience and clinical practice. *Psychologist-Psychoanalyst, 27*, 6–15.

Schore, A. N. (2014). The right brain is dominant in psychotherapy. *Psychotherapy (Chicago, Ill.)*, *51*(3), 388–397. https://doi.org/10.1037/a0037083

Shaw, R. (2003). The embodied psychotherapist: the therapist's body story. Hove ; New York: Brunner-Routledge.

Shaw, R. (2004). The embodied psychotherapist: An exploration of the therapists' somatic phenomena within the therapeutic encounter. *Psychotherapy Research*, *14*(3), 271–288. https://doi.org/10.1093/ptr/kph025

Slavin, J. H., & Rahmani, M. (2016). Slow Dancing: Mind, Body, and Sexuality in a New Relational Psychoanalysis. *Psychoanalytic Perspectives*, *13*(2),

152–167. https://doi.org/10.1080/1551806X.2016.1156430

Sletvold, J. (2015). Embodied empathy in psychotherapy: Demonstrated in supervision. *Body, Movement and Dance in Psychotherapy*, *10*(2), 82–93. https://doi.org/10.1080/17432979.2014.971873

Sletvold, J. (2016). The Analyst's Body: A Relational Perspective from the Body. *Psychoanalytic Perspectives*, *13*(2), 186–200. https://doi.org/10.1080/1551806X.2016.1156433

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research*. Los Angeles: SAGE.

Soth, M. (2002). What is "working with the body"? *The European Journal of Psychotherapy, Counselling and Health*, *5*(2), 121–133.

Stern, D. N. (1985). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*. London: Karnac Books.

Stern, D. N. (1998). The process of therapeutic change involving implicit knowledge: Some implications of developmental observations for adult psychotherapy. *Infant Mental Health Journal*, *19*(3), 300.

Stone, M. (2006). The analyst's body as tuning fork: embodied resonance in countertransference. *Journal of Analytical Psychology*, *51*(1), 109–124. https://doi.org/10.1111/j.1465-5922.2006.575_1.x

Vulcan, M. (2009). Is there any body out there?: A survey of literature on somatic countertransference and its significance for DMT. *The Arts in Psychotherapy*, *36*(5), 275–281. https://doi.org/10.1016/j.aip.2009.06.002

Wiener, J. (1994). Looking out and looking in: some reflections on "body talk"

in the consulting room. *The Journal of Analytical Psychology*, *39*(3), 331–350.

Wilkinson, R. (2000). *Minds and bodies: an introduction with readings*. London ; New York: Routledge.

Winnicott, D. W. (1949). Hate in the countertransference. *International Journal of Psychoanalysis*, *30*(2), 69–74.

Winnicott, D.W. (1960). The Theory of the Parent-Infant Relationship. *International Journal of Psycho-Analysis, 41,* 585-595.

Zoppi, L. (2017). Chilled to the bone: embodied countertransference and unspoken traumatic memories. *Journal of Analytical Psychology*, *62*(5), 701–709. https://doi.org/10.1111/1468-5922.12357

APPENDICES

Appendix A

Informed Consent Form

(In Turkish)

Bilgilendirilmiş Onam Formu

Bu çalışma İstanbul Bilgi Üniversitesi Psikoloji Bölümü öğretim üyesi Yrd. Doç Dr. Zeynep Çatay Çalışkan'ın akademik danışmanlığında Klinik Psikoloji Yüksek Lisans Tezi kapsamında Aliye Güçlü tarafından yürütülmektedir. Çalışmanın amacı psikoterapi sürecinde bedensel duyumlara odaklanmalarının terapistlerin bu süreçteki deneyimlerine etkisini irdelemektir.

Bu çalışma kapsamında, 8 hafta boyunca iki danışanınızla yapacağınız düzenli seansların ardından seans içindeki duygusal ve bedensel deneyimlerinizi içeren bir günce yazmanız beklenmektedir. Bu sürecin ardından çalışmaya katılımınızla ilgili deneyiminizi anlamak amacıyla araştırmacı ile yaklaşık 50 dakika sürmesi beklenen bir görüşme yapılacaktır. Bu görüşmenin ses kaydı alınacak ve daha sonra yazılı döküm haline getirilecektir. Günlük günce yazımının yaklaşık 20 dakikanızı alması beklenmektedir.

Güncede sizden istenen bilgi seans içeriğinden ziyade sizin öznel deneyimlerinizle ilgili olacaktır. Çalışmada danışan gizliliğini korumak adına sizden danışanlarınızın kimliğini açığa çıkaracak herhangi bir bilgi istenmeyecektir; güncenizde bu tür bilgileri gizlemeniz beklenmektedir. Bunun yanında güncenizde ve görüşmelerde isminiz veya kimliğinizi açık edecek

herhangi bir bilgi kullanılmayacak ve kimliğiniz bu araştırmadan çıkacak herhangi bir yayında paylaşılmayacaktır. Günceniz ve görüşme kaydınızın yazılı dökümü analiz edilecek ve yalnızca araştırma kapsamında ve araştırma amacına uygun kodlar haline getirilerek kullanılacaktır. Araştırma kapsamında sizden alınan tüm bilgiler sadece araştırmacının bilgisayarında güvenlik kilidiyle tutulacaktır.

Bu çalışmaya katılım gönüllülük esasına dayanmaktadır, çalışmanın herhangi bir noktasında sebep göstermeksizin çalışmadan ayrılabilirsiniz.

Araştırma ile ilgili sorularınız için araştırmacı ile iletişim kurabilirsiniz.

Katılımız ve katkılarınız için şimdiden teşekkürler.

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Bu katılımcı izin formunu okudum ve araştırma hakkında bilgi sahibi oldum. Bu çalışmaya gönüllü olarak katılmayı ve bu çalışmanın bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.

Tarih

Katılımcı İmzası

Appendix B

List of Countertransference Feelings

(In Turkish)

Aşağıda size yardımcı olması için karşıaktarımda deneyimlenebilecek muhtemel duygulara dair örnek bir liste verilmiştir. Karşıaktarım duyguları bunlarla sınırlı olmamakla birlikte, dilerseniz deneyiminizi yazarken bu listedeki örneklerden de faydalanabilirsiniz.

- Korku
- Yararlı/yardımcı
- Önemsiz
- Tiksinti
- Mutluluk
- Sıkkın
- Çökkün
- Öfke
- Boş, kuru
- Hissiz
- Hevesli/coşkulu
- Cesaretli
- Endişeli
- Boş, kuru
- Hüzün
- Güçlü
- Suçlu
- Umut
- Manipüle edilmiş
- Yutulmuş
- Merak
- Rahatlamış
- Özenli, dikkatli
- Dehşet
- Temkinli
- Hükmeden, baskın
- Gurur, kıvanç
- Hayal kırıklığına uğramış
- Küçük düşürülmiş
- Keyif
- Kayıtsız/umursam az
- Kontrol altına alınmış
- Neşe
- Şefkatli
- Kontrolü ele almış
- Acıma
- Kuşkulu
- Yaramaz/muzip
- Telaş
- Sempatik
- İşgal edilmiş
- Hayranlık
- Antipati

- Zeki
- Umutsuzluk
- Şaşırmış
- Aptal
- Rahatsızlık
- Yorgun
- Kendinden emin
- Pişmanlık
- Tehdit altında
- İlgi/özen gösteren
- Yalnızlık
- Kabul edici/açık
- Takdir edilmiş
- Keder
- Objektif
- Empatik
- Acı, ıstırap
- Bunalmış
- Tetikte
- Üzgün
- Sıkılmış
- Yüceltilmiş
- Yetersiz
- Anne gibi/anaç
- Ön yargılı
- Hüsrana uğramış
- Kafası karışmış
- Bıkkın
- Gücenmiş
- Utanmış
- Emniyetsiz/güvensiz
- Soğuk/uzak
- İlgili
- Mühim
- Reddedilmiş

Appendix C

List of Sensations

(In Turkish)

Aşağıda size yardımcı olması için seans esnasında ve/veya ardından bedeninizde deneyimleyebileceğiniz muhtemel duyumsamalara dair örnek bir liste verilmiştir. Bedensel duyumsamalar bunlarla sınırlı olmamakla birlikte, dilerseniz deneyiminizi yazarken bu listedeki örneklerden de faydalanabilirsiniz.

- Üşüme
- Baş dönmesi
- Gevşeme
- Doluluk hissi
- Terleme (tüm beden veya bölgesel; el vb.)
- Bulantı
- Canlanma
- Bedende akış hissi
- Ses kısıklığı
- Baş ağrısı
- Uyanıklık Hissi
- Nefesin derinleş-mesi
- Mide gurultusu
- Bedensel yorgunluk
- Genişleme
- Başta hafiflik hissi
- Kaşıntı
- Nefesin açılması
- Susamak
- Acı hissi

- Bedende yanma hissi
- Karın ağrısı
- Sersemlik
- Basınç hissi
- Uyku
- Mide ağrısı
- Burunda kuruluk
- Nefes sıkışması
- Esneme
- Hafiflik
- Duymakta zorluk
- Mide yanması
- Kaslarda gerginlik
- Titreme
- Ateş basması
- Gözlerin yaşarması
- Kulak çınlaması
- Nefes darlığı
- Vücutta ağırlık hissi
- Batma hissi
- Kalp atışlarında hızlanma
- Sıcaklık
- Ürperme
- Sıkışma
- Koku duyumsamak
- Cinsel organda ağrı
- Halsizlik
- Uyuşma
- Açlık
- Bedenin herhangi bir bölgesinde karıncalanma
- Kas ağrısı
- Yanma
- Ağız kuruluğu
- İstemsiz kas hareketleri
- Tuvalet ihtiyacı
- Gözlerde kuruluk
- Bulanık görüş
- Boyun tutulması
- Yutkunma güçlüğü
- Hamilelik hissi

- Göz seğirmesi
- Diş ağrısı
- Boğaz ağrısı
- Cinsel uyarılma
- Öksürmek
- Soğukluk
- Şişkinlik hissi
- Gözlerin dolması, ağlama hissi

Appendix D

Diary Questions

(In Turkish)

Seansınızı düşünerek, kendi cümlelerinizle aşağıdaki maddelerin cevaplarını içeren bir günce yazınız.
(Bu maddeler dışında gözlemleriniz olduysa, bunları da güncenize ekleyebilirsiniz.)

1. Danışanınızın seans sırasındaki baskın duygusu/veya duyguları nelerdi?
2. Sizin seans sırasındaki baskın duygunuz/veya duygularınız nelerdi?
3. Seansta belirgin olan tema(lar) nelerdi? (kısaca belirtiniz)
4. Bu seans sırasında bedeninizde ne gibi duyumsamalar gözlemlediniz? Hangi beden bölgenizde ve ne yoğunlukta olduklarını da belirtiniz. (ör: göğüs bölgemde sıkışma hissettim, kalp atışımın da bir miktar hızlandığını fark ettim)
5. Bu duyumsamalar seansın hangi noktasında belirgin oldu, ne kadar sürdü, nasıl bitti/sönümlendi ya da azaldı?
6. Bu duyumsamaları deneyimlemek seans sırasında size nasıl hissettirdi? Seans içinde onları belli bir şekilde kullandınız mı ya da onlarla baş etmek için bir şey yaptınız mı?
7. Bu duyumsamalar size ne düşündürdü ya da şu anda bunları not ederken belirgin olan çağrışımlarınız, düşünceleriniz var mı? Sizde ya da danışanda bazı duygularla ilişkili olduklarını düşünüyor musunuz?

8. Bu seans sırasında danışanla olan ilişkinizin nasıl olduğunu düşündünüz? Size göre danışanın bu seansta sizi nasıl gördüğünü/size karşı nasıl hissettiğini anlatabilir misiniz ya da bunu özetleyecek 3 sıfat belirtseniz neler olurdu? (yakın- mesafeli, güvenli- güvensiz, çatışmacı, ilgisiz, sıcak, sorgulayıcı vb.)

9. Siz danışana karşı bu seansta nasıl hissettiniz. Kısaca özetler misiniz ya da 3 sıfatla belirtseniz bunlar neler olurdu? (ör: koruyucu, empatik, kapsayıcı, soğuk, güvensiz, tehdit altında, meraklı, mesafeli vb.)

Appendix E

Interview Questions

(In Turkish)

İlk görüşmede alınacak bilgiler:

1. Terapistin mesleki tecrübesi (yıl bazında)
2. Terapistin teorik yönelimi, çalışmasında ağırlıklı olarak kullandığı teorik kavramlar, yöntemler.
3. Danışanın kısaca nasıl bir şikayetle başvurduğu (Travma öyküsü olup olmadığı)
4. Danışanın ne kadar süredir terapide olduğu.
5. Danışanın terapi sürecinin kısa bir tarifi ve danışanla ilişkisini genel olarak nasıl tanımladığı

Günce sonrası yarı yapılandırılmış görüşme soruları:

1. Çalışmaya dahil olmak konusunda nasıl hissettiniz?
2. Sizce seans sırasındaki bedensel duyumlarınızı da içeren bir günce tutmak nasıldı?
3. Bedensel deneyimler üzerine düşünmek size nasıl geldi?
4. Sizce bu bedensel deneyimlerin ortaya çıkmasını sağlayan nedir?
5. Sizce bu bedensel deneyimler seansta ortaya çıkan temalar ve duygularla nasıl ilişkilendirilebilir?

6. Size göre bedensel deneyimler üzerine düşünmek danışanla yürütülen terapi çalışmasını etkiledi mi, ne şekilde?
7. Bu danışanla (Danışan A/Danışan B) daha önce bedeninizde benzer duyumlar gözlemlemiş miydiniz?
    a. Evetse, nasıl deneyimlerdi?
    b. Evetse, bu deneyimler size nasıl hissettirmişti, nasıl anlamlandırmıştınız?

Appendix F

Information About Therapists

Therapist	Experience (year)	Theoretical Orientation	Patient	Trauma History
T1	21	Psychodynamic	A	Yes
T2	28	Psychodynamic/ Object Relations	A	No
			B	No
T3	4	Psychodynamic	A	No
			B	Yes
T4	3	Psychodynamic	A	No
			B	Yes
T5	4	Psychodynamic/ Relational	A	Yes
			B	No
T6	6	Psychodynamic/ Object Relations	A	Yes
			B	No
T7	3	Psychodynamic/ Relational	A	Yes