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TRANSFERENCE – COUNTERTRANSFERENCE IN THE PROCESS OF DEVELOPMENT OF A PSYCHOTHERAPY GROUP

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transference
countertransference
group psychotherapy stages

Summary

The aim of this article is to discuss the transference–countertransference phenomenon with reference to group psychotherapy, especially in relation to the stages of group development.
The author of the article quotes the theory of group development created by Yvonne M. Agazarian and Richard Peters, which derives from Systems-Centered Therapy (SCT). She also mentions the stages of group work described by Irvin Yalom.
The most important aspects of transference and its main types are briefly considered with reference to group psychotherapy. Through this article, the reader's attention is drawn to the ambivalent nature of transference. Readers will notice what is evident and directly present in group's communication, as well as what is hidden, omitted and passed over in silence. The text includes clinical examples from the author's workplace that help understand this phenomenon. The author points to potential difficulties that may be experienced by therapists under the influence of countertransference during different stages of group psychotherapy.

Introduction

Transference is a phenomenon of re-enactment in the present of patterns of experiencing which come from the past (mainly from one's childhood). Emotions belonging to previous relationships influence one's present perception and are transferred to other objects. Transference means repeating instead of remembering. It is unconscious [1, 2].

Countertransference, on the contrary, in the classical (narrow) approach, is defined as the unconscious reaction of the psychoanalyst to the patient's transference. This approach stays close to Freud's recommendation that the analyst should overcome his countertransference because its main source is seen as the analyst's neurotic conflicts.

The author of the article uses the term countertransference in the broad (totalistic) sense. In this approach, countertransference is viewed as the total emotional reaction of the psychoanalyst to the patient. This means that, apart from conscious and unconscious

reactions to the patient's transference, countertransference is also an answer to the analyst's own situation, as well as a means of meeting his needs, both those connected with reality and neurotic ones. The totalistic approach recommends active technical use of countertransference [3].

Types of transference

Two types of transference can be distinguished in groups: group transference (group–therapist, group–patient, group–institution) and individual transference (patient–therapist, patient–group, patient–patient, patient–institution) [4]. If the group is led by two therapists or if the therapeutic team also includes an observer, the phenomenon of transference also appears within the therapeutic team.

In group transference, the group as a whole shares an unconscious fantasy about the therapist, one of its members, or the institution within which the treatment is conducted. Group transference is characterized by high intensity, which easily arouses countertransference. Such countertransference can be often experienced as overwhelming, flooding, and all-encompassing. It is hard to control and puts pressure on one to adopt a certain attitude. Group transference can be the source of massive resistance. Under its influence, the group forces its members into specific roles, which is supposed to lead to the solution of an unconscious problem [5].

The role of the therapist promotes transference reactions, both positive and negative. In positive transference, the group leader is considered wise, the participants compete for his attention, and present attitudes of dependence and submission. Then even a blunder, a shortcoming, or an embarrassment on the part of the therapist is treated as part of his secret tactics, a well-thought-out approach to the group. In negative transference, the therapist fails, is useless, weak, and incompetent. He can be a cause of suffering and abuse [6].

Group transference, like individual transference, is ambivalent in nature. This means that, for example, the desire for closeness with the therapist, to be singled out by him, is accompanied by the fear of such a situation. The patient's more anxiety-provoking emotions determine which aspect of the transference is revealed first. For example, immediate negative transference can be understood as an expression of fear of emotional involvement [7]. In individual psychotherapy, in order to understand the ambivalent nature of transference, we sometimes need both of its dimensions to emerge. Then we can help the patient integrate the split aspects of experiencing.

In group psychotherapy, transference ambivalence can be recognized by dividing members into "camps" representing its different dimensions. Sometimes a dimension that is not directly mentioned, that escapes the patients who speak up, is experienced by the silent members of the group. When the therapist addresses them, encouraging them to express their thoughts and feelings, this allows for its disclosure. It is very important to remember this because when the majority of members support one dimension and this is accompanied by intense emotions, it is easy to succumb to such a limited understanding of group reality. When the therapist contacts the unspoken dimension of the transference in the countertransference, it is difficult to "counter" the thinking and experiencing of the numerically superior, emotional group.

Greenson calls the ambivalent nature of transference a defensive transference. For example, the patient may defend himself against romantic and erotic feelings towards the therapist or another group member through persistent hostility or extreme rationalism, emotional coldness, or correctness at the expense of emotional vivacity.

Due to the ambivalent nature of the transference phenomenon in psychotherapy, we also deal with the so-called split-based transference. Then, in order to cope with ambivalence, an individual patient (or a group) directs extremely different emotions towards two different objects [7]. In groups, this phenomenon often occurs in relation to two co-therapists.

Properly understanding and commenting on group transference often requires considerable effort on the part of the therapist, so as not to give in to its pressure or act it out. In the case of individual transference in a group, participants can be very helpful in reducing the strength of the transference reaction by offering a third position.

For example, the group had a soothing effect on the individual transference of a patient who felt hurt and had a hostile attitude towards her mother, but at the same time had friendly relationships with her siblings. She also considered her sisters and brother to be victims of her mother. When the patient began to experience the therapist in a similar way, the group tried to show her that many of the therapist's interventions were intended to help her and that they themselves did not feel similarly wronged by the therapist.

First of all, the therapist should always analyze group transferences, because they involve individual members so strongly that there is no space to work on individual issues [4].

Greenson listed the characteristic features of transference feelings: inadequate, inappropriate to the situation, excessively strong or too pale, changeable, unpredictable, rigid, and stereotyped [8]. We experience these features of transference both in individual and group therapy, as well as in life.

Usually, the transference is activated even before the first meeting in the office. Let me use an example: a patient entered the office for her first group consultation, and a look of surprise, mixed with disappointment, clearly appeared on her face. It turned out she had been expecting a much older therapist. Another patient stated during a group meeting that he was very surprised because he had assumed the participants would be "crazy" and not ordinary people dealing with problems like his.

Although group members will perceive the leader and each other in an unrealistic way due to transference, the specific nature of each stage of therapy also plays a role in shaping their perception. They find themselves in a new, unfamiliar situation, among many people about whom they only know that they have mental health problems. In addition, they usually struggle with symptoms for a long time, often for years. When we look at it this way, transference phenomena – such as the initial idealization of the therapist – cease to be surprising, as does the inevitable disappointment with a leader who does not turn out to be a healer and miracle worker.

Transference and the corresponding countertransference are the result of many different factors – the personality and age range of the participants, the purpose for which the group was established, its nature (long-term vs. short-term; open, semi-open, closed; homogeneous vs. heterogeneous), as well as the size of the group, the style of conducting the treatment, the source of financing the treatment, and the phases of the psychotherapy

process [6]. In this article, I will focus on discussing transference and countertransference phenomena in connection with the stages of treatment.

Group development dynamics

Naturally, each group develops in its own specific way because it is made up of unique people with different personalities and various interpersonal styles. In this article, I will present the group dynamics described by Yvonne M. Agazarian and Richard Peters in comparison with the corresponding stages of group formation described by Irvin Yalom.

Agazarian and Peters's concept stems from the principles of Systems-Centered Therapy (SCT), developed since the 1980s. In this approach, a group is a goal-oriented, self-regulating "living system."

Systems-Centered Therapy conceptualizes the group as three systems: the individual system, the member system, and the group-as-a-whole system. There is also a transitory fourth subsystem that appears when people come together in subgroups. These systems function in conjunction with each other and are interdependent. Agazarian compares them to Russian matryoshka dolls – the system "under" influences the system "above" and vice versa [9].

The SCT typology of group phases is one of many proposals for approaching group development, starting with Foulkes [10]. Agazarian and Peters point out that group development proceeds through a sequence of phases related to different types of systemic anxiety and the resulting defenses. At each stage, the group sets itself adaptive tasks: from regulating dependence and the need for protection (the phase of authority), through negotiating differences and separation (the phase of intimacy), to the ability to cooperate and mentalize (the phase of interdependence and work). SCT emphasizes that transference and countertransference manifestations are not only a relational phenomenon on the part of the individual, but also a way in which the entire group regulates tension and maintains cohesion. In this approach, pressure exerted on the therapist and role lock, i.e. situations in which the group imposes a specific function on the therapist or an individual, are understood as ways of maintaining the balance of the system [11].

It is difficult to precisely determine the duration of each phase. The more disturbed the patients in the group, the longer the work takes at the initial stage [12]. For example, in a group consisting primarily of individuals with experiences of violence and significant instability in their primary families (particularly due to alcohol abuse by one or both parents), a conflict arose between two patients within the first month of work. The source of the conflict was the way members coped with situations of uncertainty and fear. Being in a new situation, they expected danger and threat, so they started to create them themselves to reduce the tension associated with waiting for them and to have a sense of influence and control. Ultimately, this resulted in the dropout of one of the patients directly involved in the conflict and a long-term disruption of the process of building mutual trust, as well as the adoption of cautious, superficial topics and avoidance of mutual references and interactions.

It also happens that some groups disintegrate before they reach the separation-individuation phase. This happens when the group is dominated by patients with borderline and narcissistic disorders, who find it difficult to cope with depression related to the loss [12].

The issue of the phase of authority concerns reliance and need for care, power, and control. It reveals itself through passive and helpless dependency, counter-dependency, and the fight against authority. At this stage, a strong desire for dependency is mixed with a fear of it.

When the subphase of dependency occurs, the dominant assumption is that salvation for the entire group and its individual members lies in submission to the leader. He is entirely responsible for the safety, success, and survival of the group. He is its central figure, and initially its only bond. The conflict between the desire to receive help from the therapist and the anger caused by participating in a fearful and uncertain group experience is resolved through splitting and defensive idealization of the therapist [13]. The leader becomes a savior, a god, an omniscient and omnipotent being (Bion's Basic Assumption: Dependency) [14].

The initial stage also includes searching for similarities, forming homogeneous pairs and subgroups [15]. It is also a test of who among the participants is sympathetic and who should be treated with caution. Topics brought by individuals are kept at a safe level of rational approach to difficulties [6].

In the case of counterdependence, the group is divided into subgroups representing positive and negative transference, and the issue of aggressiveness slowly emerges. Anger and disappointment towards the therapists become evident due to the breakdown of the fantasy of fusion with an ideally satisfying object. A common enemy becomes the unifying factor within the group. This is the moment when a scapegoat can be identified within the group. Passive-aggressive struggles dominate [13].

Clinical examples

The subphase of dependency (a two-year group, which was semi-open in the first year and closed in the second; the group consisted of patients with neurotic and personality disorders aged 22–49, five men and six women; the group was led by two female therapists).

The therapist decided to create a group consisting of 7–9 members, to be led individually. At the end of the qualification process, it turned out that 11 people, in whom she did not notice any significant contraindications, were willing to use this form of treatment. Since there were no plans at the treatment center to create an additional group at that time, she decided to work with a co-therapist.

At the beginning of the group work, the therapist felt a strong sense of guilt, suggesting that she had acted unfairly towards the patients because she had informed them about the co-therapist only at the organizational meeting, during which they signed the contract, and not at the stage of the qualifying consultations. The fact is that the patients learned about the co-therapist late in the process, but still before signing the contract.

The inclusion of a second therapist seemed rational due to the larger group size and was in the interest of the patients. It was an expression of concern for them, but also of measuring intentions against strength. The feeling of guilt in the countertransference can therefore be understood here as a reaction to the group's anger in the face of the fact that

the therapist did not turn out to be an omnipotent leader who could cope with every situation on her own and did not need help.

None of the patients in the group directly expressed dissatisfaction or anger towards the therapist. It was too early to confront the potential benefactor. The beginning of therapy is a stage when patients assume dependent, conforming, passive, and submissive roles. They are afraid of not being included in the group.

The subphase of counterdependence (an indefinite semi-open group consisting of patients with neurotic and personality disorders aged 33–47, two men and eight women; led by two female therapists).

A patient who has been participating in individual psychotherapy for several years is called upon to speak. Two years earlier, he had completed two years of group psychotherapy led by one of the group therapists. A discussion begins, during which the participants divide into two opposing subgroups. One, significantly larger, doubts the therapy's chances of success, emphasizing the unsuccessful—in their opinion—efforts made so far by the patient and his therapists, highlighting the hopelessness of his situation and the futility of his efforts. The second subgroup appreciates that the patient does not give up and continues to look for ways to recover. The conversation also covers doubts about whether the treatment methods were and are appropriate for him and whether he was correctly diagnosed. The group wonders whether the patient is seriously mentally ill and should be hospitalized.

This situation can be understood as the selection of a scapegoat onto whom transference feelings were transferred – anger at the therapists and fear of their incompetence, too slow a reaction, inadequate assessment of the situation, as well as concerns about their own mental health, the seriousness of symptoms and problems and the possibility of their treatment. The second aspect of transference is the hope that perseverance in treatment will pay off. The patient was not selected by the group to speak out of concern or sympathetic interest. A court of peers was held over him, revealing the dilemmas of the other members.

Combining the subphases of counterdependency and dependency (a two-year group, which was semi-open in the first year and closed in the second; the group consisted of patients with neurotic and personality disorders aged 22–49, five men and six women; the group was led by two female therapists).

Individual patients in the group began to bring up stories in which, as parents with small children in their care, they took drugs and drank alcohol. In these situations, no sober guardian was present. They spoke of it in a humorous, carefree, and frivolous manner. When the therapist addressed the emotional climate surrounding these stories, the group focused its criticism on her, accusing her of rigidity, servility, exaggeration, and inauthenticity. The group also claimed that the therapist was pretending that she had never behaved like that.

The countertransference was dominated by fear, a sense of being overwhelmed and alone in the face of criticism coming from many members, as well as the belief that the future of the group depended on the therapist's reaction, her strength, and her ability to resist.

It seems that, on the one hand, there is a desire for a strong leader, resistant to group criticism, anger, dissatisfaction, and mass attack, and, on the other hand, there is a fear

that the leader will give in, that she will be corrupted, or that the patients will become defenseless like small children under the care of an irresponsible, weak, substance-abusing parent.

According to Yalom, the equivalent of the stage of dependency and the fight against dependency is the orientation phase. The author describes the group's basic dilemma in this initial period as a search for an answer to the question: "to be inside or outside?" [6].

A trap for the therapist in the phase of authority may be an attempt to maintain the group's belief in his or her special powers for the sake of gratification or out of fear of being devalued if any shortcomings are revealed. It sometimes happens that, under the influence of countertransference, the therapist becomes entangled in a defense against the god role imposed on him (e.g., by showing patients that he is one of them, an ordinary person with both strengths and weaknesses, and by addressing them in comments as "we"). The therapist may also, as in this clinical example, blame himself for his lack of omnipotence and try to compensate the patients for his imperfection, for example by excessive activity.

During the period of group counterdependence, under the pressure of countertransference, the therapist may sacrifice a scapegoat chosen by the members in order not to become one himself.

In SCT, the goal of a group fighting against authority is to incorporate the leader's power through rebellion or seduction. In this phase, the group attacks from a position of united strength, not from a position of helplessness and confusion, because a basic sense of security has already been established and relationships between members have been built. Individuals or subgroups organize around making the therapist a scapegoat and taking over the therapist's power. The therapist's statements are often perceived as a manifestation of the struggle for power and control [12].

The group asks the therapist numerous questions, not to get an answer, but to question it, to demonstrate his incompetence, and to check and control him. Similarly, there may be demands for advice and solutions, as well as a refusal to engage or presenting the therapist with a fait accompli – the group makes its decision to triumph over the leader. This phase is characterized by negative transference, while countertransference is characterized by fear of annihilation. Refusing to succumb to pressure to take on the role of a sadistic, retaliatory object allows one to work through aggression towards the authority and, ultimately, identify with him and his norms [13].

Fighting against authority (an indefinite semi-open group consisting of patients with neurotic and personality disorders aged 33–47, two men and six women; led by two female therapists).

A session during which a patient begins to attack the therapist, questioning the rule about refraining from drinking during the meeting, could be an example here. The patient demands explanations and justifications. He emphasizes the absurdity of this principle. More and more patients join in his criticism, expressing their incomprehension and outrage, considering the rule inhumane. Only after several minutes of attack does a second faction emerge from the group, defending the pair of therapists. This faction presents its arguments for upholding the principle.

Often, discussions about authority do not take such a direct form. Instead, the conversation may include rigorous, unempathetic teachers, incompetent doctors who disrespect

patients, politicians who only care about their own interests, authoritarian bosses, and inept or short-sighted architects.

Yalom calls the fight against authority the stage of conflict, domination, and rebellion. He describes the group dilemma as "up or down." According to the author, conflict may arise both between the group and the leader and among the members. A hierarchy and a "social pecking order" emerge here. Yalom points out that the struggle for control often manifests itself when a new participant joins who, instead of recognizing his place in the hierarchy and showing respect to the more senior members, feels comfortable, on equal terms, or tries to dominate [6].

Sometimes, the struggle with authority triggers countertransference, under the pressure of which the therapist may want to show "who is in charge." For example, the leader may comment on the psychopathology of patients without proper timing, not out of a desire to help them understand the source of their difficulties, but to show that he or she has an advantage over them.

For Agazarian and Peters, the beginning of the next phase – the phase of intimacy – is the subphase of group enchantment. Then energy is redirected from the leader to the members. The group feels wonderful, strong, independent, and does not need a therapist. It becomes an idealized family in which hopes are placed to satisfy the desire for closeness. Unauthorized meetings outside the group may occur. Ultimately, closeness activates the "too close, too far" dynamic, which ends in a transition to disenchantment. This is a phase of pseudo-independence in which members may deny ambivalence and activate manic defenses against depression and anxiety [11].

Enchantment with the group (a two-year group, which was semi-open in the first year and closed in the second; the group consisted of patients with neurotic disorders and personality disorders aged 29–46, three men and four women; it was led by one therapist).

A group that integrates strongly during breaks, when there are lively, prolonged, emotional discussions, while in the presence of the therapist the patients are rather withdrawn and reserved, could be an example here.

In countertransference, there is a feeling of exclusion, of being unimportant, unwanted, uninteresting, and sometimes also jealousy of intra-group relationships.

A similar phenomenon occurs in a supervision group whose members plan supervision without a supervisor in an office provided by one of the supervisees.

When group members lose hope for symbiosis and the fantasy of group omnipotence collapses, it results in disenchantment with the group (another subphase of the stage of intimacy). A sense of hopelessness, loneliness, and despair occurs. The group is fragmented into individuals. Patients adopt alienating, suspicious attitudes. They experience identity crises and narcissistic wounds.

This stage is characterized by numerous late arrivals and absences of patients, withdrawal or reduction of verbal activity (both in terms of the content contributed by individual patients and in providing feedback), complaints about the group, and sarcasm in statements. There may be accusations such as "I've said it before" and complaints about the return of symptoms. In countertransference, the therapist experiences fear of the group disintegrating [13].

The danger of acting out countertransference in the case of enchantment and disenchantment with the group may take the form of trying to gain re-acceptance from its members through submissive behavior, wanting to show the advantages of having a therapist or being in group therapy, giving up analyzing threads related to reluctance and anger, sometimes showing patients that they are doing something wrong and that is why they are disappointed and angry, as well as trying to equalize the participants' position with the leader's role so as not to feel excluded.

In the SCT concept, in the interdependence and work phase, the group is already able to work effectively on the individual problems of each member. The topics brought in do not change, but the level of reflectiveness, symbolic thinking, the ability to contain tensions and frustrations changes, tolerance for ambivalence increases significantly, and the possibility of connecting the "here and now" with the "there and then" arises. The group's motive is individual and shared responsibility for progress and development. The therapist becomes a more equal partner. Group countertransferences towards individual participants are a very valuable source of information [11].

Yalom includes the phases of enchantment and disillusionment with the group, as well as mutual dependence and work in the stage of cohesion, in which the experiences and actions of members revolve around intimacy and closeness, the dilemma of "too far or too close" [6].

In long-term psychotherapy, these phases may repeat many times. Regression may occur due to ongoing changes or crisis situations. In this context, regression does not necessarily mean a negative phenomenon, but rather a natural reaction to threat and uncertainty, resulting in turning back to an authority figure as a person in whom hopes and expectations are placed for resolving difficulties.

Group reaction to changes – the first example (a two-year group, which was semi-open in the first year and closed in the second; the group consisted of patients with neurotic and personality disorders aged 32–56, two men and five women; the group was led by two female therapists).

An example of a situation illustrating a regression to an earlier phase of group development is one in which, in a group that had been working for a year and a half, after losing two members due to dropouts and in the face of doubts about remaining in the group expressed by the other participants, one of the patients began to refer with admiration to the failed assassination attempt on the President of the United States, Donald Trump. Trump not only survived the attack but, wounded and with blood on his face, stood up and began waving his fist at the crowd in a triumphant gesture. This can be interpreted as a desire to have an indestructible, strong leader in the face of fear of the group falling apart, but also as anger at the therapists, expressed by the shooting assassin, for allowing a dangerous situation to arise and the "death" of several participants. In order for "shots and injuries" not to kill the group, the leader must first rise victoriously from the fall.

In cases of threat, uncertainty, or change, the therapist takes on particular importance and transferences may largely revolve around him, as in the beginning of therapy.

The above example refers to a serious threat to the group's existence. However, there are situations where the threat is less obvious, such as introducing a new member to the group.

Group reaction to changes – the second example (an indefinite semi-open group consisting of patients with neurotic and personality disorders aged 33–47, two men and six women; it was led by two female therapists).

The example involves a more advanced group, working for a year. Its members were wondering where a new participant would sit and how to react if he took their place. Should they ask him to move, or let him stay and then maybe put a chair for themselves next to him? Then the discussion moved to one of the therapists, and doubts arose as to how she would react if her chair was taken. The group also expressed a desire to challenge the new person and offer him the therapist's chair, so as to put him in a difficult situation and test both his and the therapist's reaction.

One can read here anger at the joining of another participant, exposing the group to stress and the loss of some space. However, in this case, group members also expressed appreciation for the therapist, whom they perceived as assertive. The anger was therefore also related to the fact that the therapist's assertiveness did not satisfy the various desires and expectations of the group, although, on the other hand, it impressed the group and served its development. The participants were curious how the leader would react to the new situation and what example of conduct he would set. The group consolidated here, coalescing in opposition to the new member, but also to the leader, who remained the most important point of reference.

The end of therapy

The final phase involves completing treatment and working with separation anxiety. Ending is one of the most difficult existential situations.

On the one hand, the final stage of therapy confronts the participants with the inevitability of transience, and thus with the inherent endings, losses, and separations, which, as Roger Money-Kyrle noted, is one of the three (along with dependence on breasts and the couple's creativity) aspects of reality that are particularly difficult to bear [after: 16]. On the other hand, there is an activation of separation fears described by Margaret Mahler (early childhood) and Peter Blos (adolescence), which are part of the separation-individuation process and are related to the prospect of losing the caring object (group, therapist) and the need to make an independent effort to observe oneself and correct one's behavior [17, 18]. Some patients may feel that – just as before from their parents – they did not receive enough from either the therapist or the group. Others, on the other hand, may blame themselves for what they perceive to be unsatisfactory work results. Participants also face memories of previous losses in their lives [2, 12, 15].

Ending therapy evokes regret, anger, sadness, fear, disappointment, feeling moved, gratitude, and relief. When patients have trouble coping with some of the above-mentioned feelings, they use defense mechanisms such as:

— denial (then patients bring up new topics, avoid awareness of the approaching separation date, and try to make up for lost time);

— regression (patients report worsening of symptoms; a return of dependent attitudes often occurs);

— manic defenses (participants may devalue the group and idealize loneliness or other relationships outside the group);
— acting out (in the form of a dropout – "I will leave before I am abandoned" – and activities for a second life, i.e. attempts to create a replacement group, search for a new therapy, and negotiate an extension of the group's duration) [2, 6].

In term groups, where all patients are completing treatment at the same time, this is a particularly difficult moment because it confronts all participants at the same time with the prospect of termination. In the case of long-term groups without a specific duration, individual patients complete therapy at different times, which means that the problems mentioned above occur with less intensity.

It is worth remembering that we should work on the issue of endings throughout the therapy – for example, when Christmas or holiday breaks are approaching. This issue should not be left to the very end.

The author's observations suggest that ending is a time when countertransference pressure may lead to deviations from the setting (e.g., the desire to extend the duration of both the entire group psychotherapy process and each group session) or to "give more" and become more active (the therapist deepening the new content and taking on the burden of the group's work). At this stage, therapists may often be driven by a sense of guilt and fear that patients are not yet ready to leave the group and that they have not received enough. In other cases, countertransference pressures push them to avoid the topic of separation with their patients, especially since raising the issue of endings arouses resistance and hostility. It may also lead to persistent reminders of the end and to trying to speed things up, without taking into account the pace of patients' adaptation.

It is important for the leader to recognize that the completion phase also consists of stages. These include:

— denial (there are signs of increased tension in the group, "random" statements relating to separations and losses; the group does not tolerate clarifications and interpretations well);
— dependency and anger (there are themes of death, funerals, danger, apocalypse, and searching for rescue; conversations revolve around bad, abandoning mothers and the longing for better mothers; guilt is attributed to caregivers; the emotional climate is filled with despair, terror, hostility, and rage);
— confrontation (feelings can be named in a more direct way and related to the current situation of the group; the group is divided into people expressing separation anxiety and the desire for dependence and those who strive for separation and independence);
— acceptance (patients raise issues of changes, new relationships, and solutions, take stock of their work, and refer to the time axis: past-present-future) [19].

Conclusion

Although it is impossible to precisely predict all the possible ways transference and countertransference may manifest in group psychotherapy, knowledge of the specifics of the phases of group development is very helpful in diagnosing the current situation and selecting working methods and the type of therapist involvement tailored to the current needs and difficulties of the members.

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