Section: Modern PPT practice

PSYCHODYNAMIC ASPECTS OF PROFESSIONAL RESISTANCE IN TRAUMA TREATMENT

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Abstract

The article is devoted to the study of the phenomenon of psychotherapists' resistance in the work with psychotrauma, considered within the framework of the psychodynamic approach and positive psychotherapy. The author analyses the internal and external factors that cause resistance: secondary traumatisation, emotional burnout, unprocessed personal or transgenerational trauma, countertransference, stigmatisation of violence, religious beliefs, and ethical dilemmas. Particular attention is paid to the physical, emotional, and cognitive manifestations of resistance in the four spheres of the therapist's life. A five-stage model of self-help based on positive psychotherapy is proposed as a tool for overcoming professional disadaptation. The article proposes for discussion that the therapist's resistance is not a manifestation of incompetence, but rather a reflection of deep internal dynamics that can serve as a resource for growth. The practical significance of this work lies in creating a holistic conceptual framework for self-reflection, supervisory support, and the professional development of therapists working with trauma.

Keywords: psychotherapist resistance, trauma treatment, psychodynamic approach, Positive Psychotherapy, emotional burnout

Introduction

In today's context of a significant increase in requests for psychotherapeutic assistance due to wars, pandemics, man-made and natural disasters, the issue of working with trauma is becoming particularly relevant. Psychotherapy of trauma requires not only high professional training, but also a deep understanding of one's internal dynamics, which significantly affects the course of the therapeutic process. In working with traumatised clients, a psychotherapist is not a passive observer but an active participant in the interaction, and their emotional reactions, unconscious processes, and forms of resistance can both facilitate and complicate treatment.

Traditionally, psychotherapy focuses on the client's resistance. However, in the case of working with traumatic experiences, therapist resistance - manifestations of avoidance, emotional withdrawal, overcontrol, or identification - becomes an equally important object of study and understanding. The study of therapist resistance enables a deeper understanding of the mechanisms of interaction in a therapeutic dyad and enhances the effectiveness of treatment.

Despite numerous studies of client resistance, therapist resistance, especially in trauma work, remains a less developed aspect that has a significant impact on the success of the therapeutic process.

The purpose of this article is to analyse the phenomenon of psychotherapist resistance in trauma work within the psychodynamic

approach, with a special focus on the concepts of positive psychotherapy.

The article discusses the theoretical foundations of resistance and trauma and their role in the psychodynamic process of positive psychotherapy to explore the topic further.

Methodology

This study employed theoretical analysis methods, including synthesis, analysis, generalization, and interpretation. The theoretical and methodological basis was the classical psychoanalytic approaches (Freud, S.; Freud, A.; Fenichel, O.; Lacan, J.; McWilliams, N. and others), the concepts of trauma therapy (Herman, J.; van der Kolk, B.; Alexander, F.; Ruppert, F. and others), as well as positive psychotherapy, founded by Peseschkian, N. and developed by Remmers, A, Peseschkian, H., Kirillov, I. and others. The research integrates interdisciplinary approaches - neurobiological aspects of trauma, phenomena of secondary traumatisation, and ethical dimensions of psychotherapeutic practice.

2.1. Definition of the phenomenon of trauma

Analysing the phenomenon of psychotherapist resistance in trauma work requires, first of all, determining the nature of trauma itself as a psychopathological process. In the psychodynamic tradition, trauma is viewed not only as an external event but as an experience that exceeds the adaptive capacities of the individual and leads to long-term changes in its structure.

S. Freud (1992) was one of the first to define the concept of psychological trauma, interpreting it as a consequence of the inability to integrate excessive affect, which leads to obsessive *repetition* of traumatic situations (*repetition compulsion*). E. Bibring (1953) focused on the experience of total helplessness during traumatic events, which contributes to the formation of deep mental disorders. F. Alexander (2004) emphasized that traumatic experiences change not only emotional reactions but also the personality structure, affecting defense mechanisms and interpersonal interactions. E. Erikson (2002) emphasised that the violation of a basic sense of trust in early development has long-lasting consequences for identity formation.

In the modern understanding of trauma presented by J. Herman (2021), the emphasis is on the destruction of basic structures of safety, control, and connection, which leads to the development of post-traumatic disorders and profound personality changes. Processing traumatic experiences in psychotherapy usually involves three main stages: stabilisation (creating a safe space and restoring a basic sense of control), reconstruction of traumatic events (integrating memories without re-traumatisation), and integration of experience into a holistic personality structure (Herman, 2021; van der Kolk, 2014).

Within the framework of positive and transcultural psychotherapy, Nossrat Peseschkian (1987) emphasised that the accumulation of small negative experiences (microtraumas) forms vulnerable areas of the personality, which later become the focus of conflicts and psychosomatic disorders, despite their apparent insignificance. A. Remmers (2023) interprets trauma as a destructive experience that damages basic personal capacities such as trust, love, patience and acceptance. Traumatic events change the perception of reality, disrupt affective regulation, and contribute to the formation of closed post-traumatic behavioural patterns.

In the context of working with trauma, U. Boessmann and A. Remmers (2022) clarify that the term "trauma" applies to both the event that causes damage and long-term post-traumatic stress. Conceptually, it is more appropriate to talk about traumatic experience, its processing, and consequences.

The distinction between macro-trauma and micro-trauma is particularly noteworthy. I. Kirillov (2019) notes that both large catastrophic events and cumulative small stressors can have an equally significant impact on mental functioning. F. Ruppert (2010) proposed a model of splitting the personality after trauma into three parts: traumatised, surviving, and healthy. Macro-events evoke acute emotional reactions and leave lasting impressions, while micro-events gradually erode the emotional state through cumulative effects. It is important to analyse your reactions to events to prevent the development of trauma. The mechanism of trauma formation can be described as follows: the outcome of an event (trauma or integration into the norm) depends on the ratio of available human resources at the time of the event and

the resources spent on its processing. M. Tyshchenko (2025) presents the following formula to illustrate the occurrence of trauma (Fig. 1).

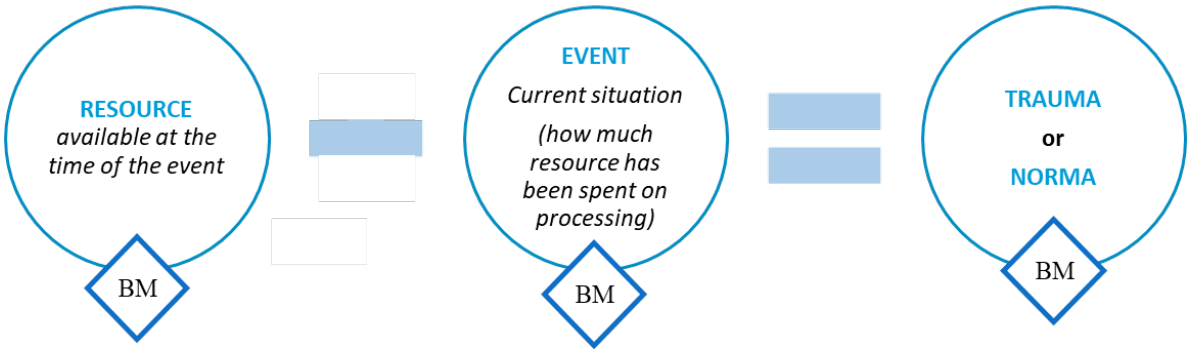

Figure 1. he formula of trauma: resource versus event
Tyshchenko M. (2025)

In the context of dealing with the consequences of microtrauma, Nossrat Peseschkian (2006) emphasises the importance of analysing the patient's current capacities. It is necessary to identify which capacities have been affected by microtrauma, whether they have been delayed in development, neglected, or formed one-sidedly. Assessing these changes in the psychodynamic, family, and social contexts enables a deeper understanding of the mechanisms underlying conflict. It supports the integration of traumatic experience into the therapeutic process.

It is additionally important to consider the neurobiological aspects of trauma. According to B. van der Kolk (2014), traumatic experiences activate evolutionarily ancient brain regions that trigger automatic fight-or-flight or freeze responses. The inability to complete these defensive reactions leads to chronic post-traumatic activation.

The phenomenon *of developmental trauma* is particularly complex, where persistent disorders arise from prolonged exposure to disruptive relationships in childhood (Herman, 1992; van der Kolk, 2014). The lack of stable security experiences in the early stages of development creates vulnerability to further traumatic events.

In addition, it is important to take into account post-traumatic reactivity - the phenomenon of increased emotional sensitivity to triggers, flashbacks, and emotional outbursts that are automatically activated in response to reminders of traumatic experiences (Herman, 1992; van der Kolk, 2014).

When working with trauma, the role of countertransference is equally important. A psychotherapist's deep emotional response to a client's traumatic experiences can become both a resource for empathy and a source of resistance or avoidance. Adequate reflection on countertransference enables the avoidance of both identification with and rejection of the client's pain. According to Tyshchenko(2025), working with traumatic experiences is often accompanied by strong emotional reactions in the therapist, such as feelings of powerlessness, anger, and the desire to save or avoid contact. These reactions can be manifested through four channels: emotional feelings, cognitive evaluations, associations with one's own experience, and intuitive fantasies. In such cases, the risk of secondary trauma for the therapist increases, such as emotional burnout, loss of empathy, or the formation of defensive distancing. Regular supervision, the development of skills in reflection, countertransference, and self-regulation, are necessary conditions for maintaining therapeutic presence (Figley, 2013; Pearlman & Saakvitne, 2013).

Thus, in psychodynamic and positive psychotherapy, trauma is viewed as a multilevel disruption of the personal structure that requires stabilisation, integration of experience, and development of new resources to restore integrity. Knowledge of these mechanisms creates the necessary basis for further analysis of the phenomenon of psychotherapist resistance in working with trauma. Interaction with the patient's traumatic material inevitably activates the psychotherapist's internal defence mechanisms, such as projective identification, denial, or dissociation (Freud, 1993). Awareness of one's resistance is critical to maintaining the

therapeutic alliance and preventing unconscious retraumatisation.

2.2 Definition of the phenomenon of resistance

Interaction with traumatic experience inevitably activates internal defence mechanisms in both the patient and the psychotherapist, which manifest themselves in the phenomenon of resistance.

Resistance in psychotherapy is a key concept in the psychodynamic approach. It refers to internal psychological barriers that prevent change, even when this change is perceived as desirable. Resistance is considered a reaction to approaching a painful or unacceptable experience, and at the same time, a signal of the actualization of deep internal conflicts. Its understanding has evolved within various psychotherapeutic schools, from classical psychoanalysis to modern integrative approaches.

The concept of Widerstand was first introduced by Freud (1895) and later elaborated in his work "Remembering, Repeating, and Working-Through" (1914/2024), where he defined resistance as an internal process by which a patient unconsciously avoids painful memories and complex affective experiences that attempt to enter consciousness. In his subsequent works (1936; 1990), Freud emphasized that resistance is the result of the interaction of different aspects of the psyche - the Id, Ego, and Superego. Fenichel (2013), based on psychoanalytic ideas, was one of the first to systematically classify sources of resistance according to mental structures: the Id (fear of unconscious impulses), the Ego (defence mechanisms, such as rationalization, displacement, and intellectualization), and the Superego (guilt that blocks change). Freud (1993) proposed a psychoanalytic classification of the defence mechanisms of the Ego, which later became the basis for explaining various forms of resistance. She viewed defense as an adaptive mechanism that performs a stabilizing function for the psyche and, at the same time, as a barrier in the psychotherapeutic process (Freud, 1993). In the modern psychoanalytic literature, particularly in the works of McWilliams (1998), the classification of forms of resistance has been generalized and adapted for clinical use. It includes such manifestations as transference resistance (the affective projection of past experiences onto the therapist), secondary gain (unconsciously maintaining the benefits of symptoms), moral resistance (the impact of severe supervision on the ability to change), and avoidance and rationalization (ego resistance as an intellectual barrier). At the same time, the works of Lacan (2001) emphasise that resistance is not only an internal mental process, but also a structural element of analytical interaction. Lacan points to the role of the analyst himself as a source of resistance: "It is not the patient who resists the analytical process - it is the analyst who creates resistance" (Lacan, 2001).

In positive psychotherapy, resistance is seen not only as an obstacle but also as an important diagnostic and therapeutic element. The concept of resistance in positive psychotherapy has been studied by Peseschkian (1987), Henrichs and Hum (2020), Peseschkian and Remmers (2020), Lytvynenko, Zlatova, Karikash and Zhumatii (2020), and Remmers (2025), considering it as an important element of the therapeutic process, which can be both an obstacle and a resource for deeper processing of the patient's internal conflicts.

Peseschkian (1987) considers resistance as a form of patient self-defence based on the preservation of basic concepts and coping mechanisms formed in childhood. He identifies the main forms of resistance: verbal (silence, avoidance), behavioral (lateness, skipping therapy), cognitive (rationalization), and emotional (idealization of the therapist, fear of deep involvement). Resistance is interpreted as a model situation for the patient's conflict behaviour, reproducing internal contradictions and interpersonal difficulties. In positive psychotherapy, resistance is viewed not as an obstacle but as a resource for deeper diagnosis and transformation of the patient; the therapist's task is not to fight resistance but to utilize it constructively. Peseschkian also draws attention to specific forms of resistance, including therapist idealisation and the "rubber wall" - formal acceptance of interpretations without emotional involvement, which makes real change difficult (N. Peseschkian, 1987). Henrichs and Hum (2020) emphasise that a positive reappraisal of symptoms and conflicts helps to reduce resistance and facilitates access to hidden mental material. H. Peseschkian and Remmers (2020) note that the use of stories and proverbs helps to overcome resistance, as it

creates additional space for transference and facilitates associative processing of deep conflicts. Lytvynenko and co-authors (2020) emphasise the importance of humour and anecdotes as a means of reducing tension and overcoming resistance associated with difficult emotions. According to Parruca (2022), when working with traumatised clients, resistance manifests itself through blocking access to traumatic experiences, and it can be overcome by using integrative tools, including psychosocial games, which activate hidden capacities and reduce resistance. Remmers (2025) considers resistance in group therapy as a form of multidimensional transference that requires deep reflection and active involvement on the part of the leading therapist's personality. The author demonstrates how resistance in the group process can change the dynamics by unconsciously reproducing conflicts of power and subordination that stem from the participants' family experience.

In positive psychodynamic therapy, resistance is seen as a defensive response to the loss of security and trust that occurs after a traumatic experience. Changes in the personality structure are manifested in a distorted perception of reality, impaired impulse regulation, and limited emotional communication (Remmers, 2023). Resistance is associated with the reproduction of basic conflicts, such as doubt, fear, loss of trust, and hope, and can be diagnosed through the phenomena of countertransference in the therapeutic process.

Thus, resistance in positive psychotherapy is not viewed as an obstacle but as a resource for deeper understanding of the patient and advancement of the therapeutic process. In addition, positive psychotherapy emphasises the value of positive transference as a resource for creating a stable therapeutic alliance. Through the activation of trust, internal images of support and hope, positive transference can be used as a tool for integrating traumatic experiences (N. Peseschkian, 1987; Remmers, 2025).

Based on the theoretical analysis, the systematisation of the key factors that determine the emergence of resistance in psychotherapists when working with psychotrauma is carried out. This section summarizes the study's results, providing a deeper understanding of the multidimensional nature of resistance as an emotional, cognitive, and behavioral phenomenon. The discussion of the identified determinants contributes to a deeper understanding of the intrapersonal, professional, socio-cultural, and moral factors that influence the effectiveness of the therapeutic process. It outlines prospects for further research in the areas of preventing professional burnout, supporting the therapeutic alliance, and maintaining the ethical stability of a specialist.

The therapist's resistance to working with trauma can manifest itself at different levels - from physiological reactions and emotional exhaustion to deep unconscious defence mechanisms, ethical conflicts, and difficulties in countertransference. This article identifies the following main vectors of analysis: physiological and emotional reactions; psychological factors (emotional burnout, secondary traumatisation, etc.); unprocessed personal trauma of the psychotherapist; stigma and social prejudice about trauma as factors of resistance; religiosity and spirituality as a source of support or avoidance; ethical and moral dilemmas; and difficulties of transfer and countertransfer.

Below is the *"Model of Multilevel Resistance of a Psychotherapist*", which visualises these factors in their interconnectedness (Fig. 2).

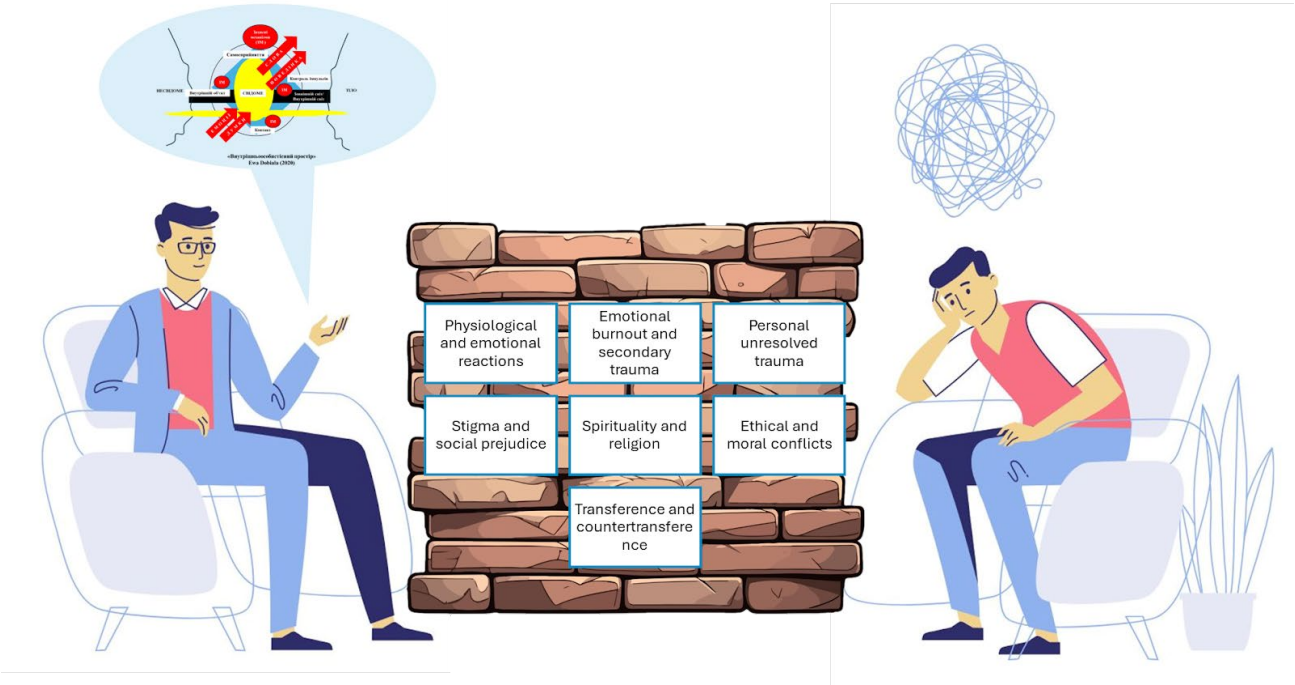

Figure 2. Model of multi-level resistance of a psychotherapist

The main factors that form internal barriers for a psychotherapist when working with traumatic topics are schematically depicted. Each "brick" symbolises a separate dimension of resistance - physiological, emotional, cognitive, sociocultural, or ethical. The image of the wall illustrates the unconscious construction of psychological defences that make it difficult to form a deep therapeutic contact. In the upper left corner is a conceptual background - a model of intrapersonal space (Dobiala, 2020) - which explains the function of defense mechanisms in the context of unprocessed trauma.

Discussion

3.1. Physiological and emotional reactions

Working with traumatic stories of clients activates basic stress reactions in the psychotherapist - "fight", "flight", "freeze" (fight-flight-freeze), which have both physiological and emotional components. Modern research (Brewin et al., 2000; Figley, 2013; van der Kolk, 2014; Sprang et al., 2007) confirms that prolonged exposure to traumatic material leads to activation of the hypothalamic-pituitary-adrenal axis, increased cortisol levels, muscle tension, anxiety, and sleep disorders. All this can cause emotional exhaustion and contribute to the development of psychosomatic symptoms.

For example, the fight response can manifest itself as irritability, aggressiveness, or an unconscious attempt to "protect" oneself from excessive emotional stress. The flight response is sometimes expressed as avoidance of contact, emotional withdrawal, reduced empathy, or a desire to stop working with a specific category of clients. The freeze response is characterised by states of dissociation, emotional disconnection, and internal paralysis during or after sessions where intense traumatic events have been discussed. Such physiological and emotional reactions can form the basis for the development of secondary traumatisation or professional burnout, phenomena that significantly affect the quality of the therapeutic process and can act as powerful sources of resistance (Figley, 2013; Tyshchenko, 2025). Adequate recognition of these conditions, supervisory support, and care for internal resources are key factors in maintaining the professional effectiveness of a psychotherapist.

We propose considering the resistance that arises in the therapist as a response to working with trauma through the lens of the model of the "four spheres of conflict and experience processing" in positive psychotherapy (Peseschkian, 1987). Each of the basic stress reactions - "fight", "flight", "freeze" - can be recognised within one of the four spheres:

- **The body sphere (the physical dimension).** The bodily level of stress is manifested through somatic symptoms: increased muscle tension, sleep disturbances, and autonomic reactions.

The "fight" reaction is manifested here as bodily mobilization (readiness to fight), the "flight" reaction is characterized by a desire to avoid bodily discomfort, and the "freeze" reaction is expressed as bodily numbness or loss of energy. This indicates the need for targeted care to address basic physical needs and restore the resource.

- **The achievement sphere (role identity, action).** In the area of achievement, stress activates the desire to act impulsively or perfectionistically (the "fight" response), avoid responsibility or tasks (the "flight" response), or lose the ability to take initiative and make decisions (the "freeze" response). In this area, it is especially important to maintain a realistic perception of your professional capacities and limitations, maintaining a balance between ambition and self-support.
- **The relationships sphere (emotional interaction).** At the level of interpersonal relationships, the "fight" response can manifest itself as intolerance or aggression towards clients or colleagues, the "flight" response as emotional distancing or avoidance of deep contact, and the "freeze" response as emotional numbness or inertia in interaction. The ability to empathise, build trust, and maintain a safe atmosphere in the therapeutic alliance is at risk.
- **The fantasies and the future sphere (values, perceptions, hopes).** In the dimension of fantasies and goals, the "fight" reaction can be manifested through idealised, unrealistic aspirations to immediately "change the world" or "save everyone", the "flight" reaction through escape into passivity or abandonment of professional ambitions, and the "freeze" reaction through loss of meaning, hopelessness and a decrease in faith in the possibility of change. It is important to restore the ability to see the future and maintain inner hope.

Such an analysis contributes not only to a better understanding of the dynamics of resistance but also to the development of personalized approaches to stabilizing the therapist's condition. A generalised representation of this correlation is shown in Figure 3, "Therapist's stress reactions in the four areas of the Balance Model."

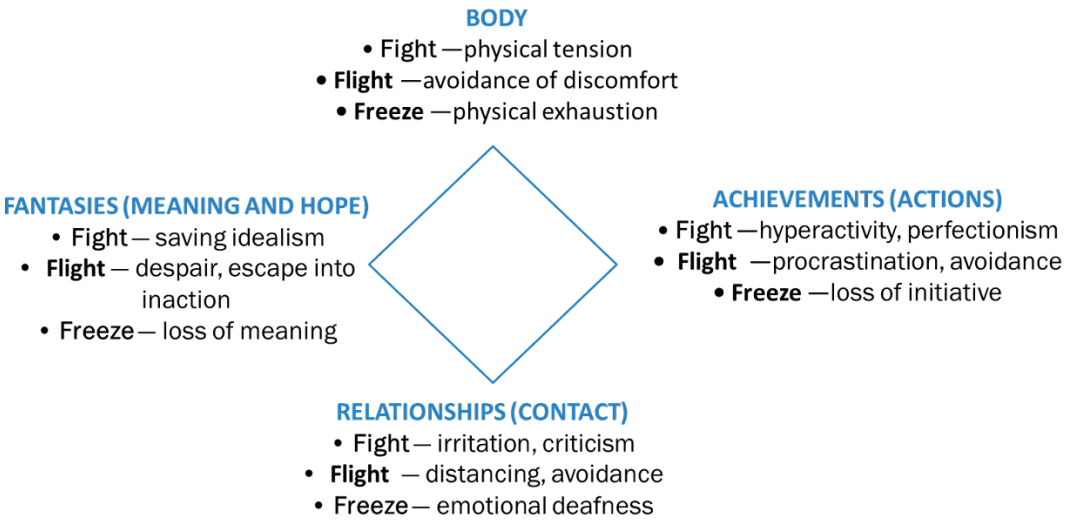

Figure 3. Stress reactions of a psychotherapist in the four areas of the Balance Model

Thus, Peseschkian's (1987) model of the four spheres is an effective tool not only for analysing the client's condition, but also for the psychotherapist's self-observation. It allows identifying manifestations of resistance and determining the directions of stabilisation by restoring balance in each of the spheres. This approach helps prevent professional burnout, supports the therapist's emotional well-being, and maintains quality therapeutic contact.

3.2. Psychological reasons: emotional burnout and secondary trauma

Prolonged contact with clients' traumatic stories leads to the phenomenon of oversaturation with other people's pain, which becomes a significant factor in the therapist's resistance. The main psychological consequences of this process are emotional burnout and secondary trauma.

Emotional burnout is manifested in the loss of empathy, increased cynicism, fatigue, and professional demotivation. According to Figley (1995), *compassion fatigue* is a state of emotional, mental, and physical exhaustion that results from prolonged empathy with other people's suffering.

Secondary traumatisation includes the emergence of PTSD-like symptoms in the therapist: sleep disturbances, intrusive images, and increased anxiety. According to J. Herman (2021), secondary traumatisation occurs even with indirect contact with someone else's trauma, for example, when listening to clients' traumatic stories.

There are several key phenomena in this context:

- *Compassion fatigue* is an emotional, mental, and physical exhaustion due to prolonged empathy with someone else's pain (Figley, 1995).
- *Vicarious trauma* is a cumulative change in a therapist's cognitive schemas and beliefs as a result of repeatedly hearing traumatic stories (McCann & Pearlman, 1990).
- *Secondary traumatic stress* is the development of symptoms of post-traumatic stress disorder after indirect contact with the trauma of others (Figley, 1995; Herman, 2021).
- *Retraumatisation* is the activation of the therapist's traumatic history under the influence of the client's experiences or the therapeutic situation, including the phenomena of transference and countertransference (Bloom, 2013; Herman, 2021; van der Kolk, 2014).

These phenomena form an interconnected set of psychological factors that increase the risk of developing professional resistance, reduce the quality of therapeutic contact, and, in the long run, can lead to burnout, a loss of empathy, and a decline in motivation for professional activity. Given their cumulative effect, it is important to implement targeted prevention through regular supervision, reflective practice, psychohygiene, and work with therapists' resources.

In view of this, we propose an adapted version of the five-stage model of positive psychotherapy (Peseschkian, 1987) as a strategy for individual work with the phenomena of compassion fatigue, vicarious trauma, secondary traumatisation, and retraumatisation. This model allows not only to diagnose elements of professional exhaustion, but also to integrate holistic tools of self-reflection, encouragement, and expansion of life goals, which are characteristic of positive psychotherapy, into the recovery process. The sequential passage of the five stages creates a structured path to stabilising the internal state of a specialist.

We propose a five-step model for dealing with therapist emotional burnout and secondary trauma, which includes the five stages described below.

1. **Observation/distancing stage:** awareness of one's own physiological, emotional and behavioural reactions (signs of compassion fatigue, vicarious trauma, secondary trauma, retraumatisation); creating a safe internal distance to analyse personal reactions without self-blame; self-observation with recording the appearance of symptoms - loss of empathy, anxiety, flashbacks, cognitive changes.
2. **Inventory stage:** forming an "internal list" - what symptoms or experiences are manifested; distribution of identified reactions according to the Balance Model - which areas are affected (body, achievements, relationships, fantasies); identification of sources of stress - which cases or topics of clients trigger resistance or fatigue.
3. **The stage of situational encouragement:** searching for and strengthening personal resources, which helps me to restore balance in each area; using stories, metaphors, humour for self-support (a technique of positive psychotherapy); introducing regular self-care practices - sleep, nutrition, sports, social support.
4. **Verbalisation stage:** open discussion of experiences in supervision or a professional group; awareness and

articulation of my own needs - where I need support and where I need to adjust my workload; reflection on the impact of compassion fatigue or secondary trauma on my work and ways to restore empathy and professional identity.

5. **The stage of expanding goals:** rethinking one's own motivation in dealing with trauma; forming new personal and professional goals - how to maintain empathy while remaining resilient; implementing a plan for long-term self-preservation - learning self-regulation, expanding sources of pleasure and meaning outside of work.

A summary Table 1 is also provided, which can be used as a practical tool for self-diagnosis and self-care planning.

Table 1.
Five-step model of working with compassion fatigue, vicarious trauma, and secondary traumatisation in psychotherapists

Step	*Objectives*	*Practical instructions*
1. Distancing	Understand the physiological and emotional symptoms of stress	Keep a diary of observations; find triggers
2. Inventory	Identify areas of disturbance (body, achievements, relationships, fantasies)	Make a list of symptoms and reactions
3. Situational encouragement	Activate resources in each area	Introduce regular resource habits (sleep, movement, humour, social connections)
4. Verbalisation	Reflecting on and discussing your own emotions and anxieties	Supervision, discussion in collegial groups
5. Expanding the goals	Create a self-preservation plan and find new motivation	Finding new meanings, expanding sources of pleasure outside of work

3.3 Unprocessed personal trauma of the psychotherapist

The therapist's unprocessed personal trauma - especially those aspects of it that have remained unconscious or have been repressed - can be a source of deep internal conflict that manifests itself in the form of therapeutic resistance. Such resistance is usually latent and can manifest itself through emotional distancing, excessive empathy, difficulties in setting professional boundaries, hyperreactivity, or avoidance of certain categories of clients (e.g., survivors of violence, loss, divorce, war, or disaster).

According to the psychodynamic hypothesis underlying positive psychotherapy (Bossmann & Remmers, 2024), behavioural and symptomatic manifestations can be seen as signals of actualised unconscious internal conflict (ACI), which arises as a result of the reactivation of the base conflict (BC) under the influence of an external stressor - the actual conflict (AC). The formula IC = AC × BC (Kirillov, 2019) illustrates this mechanism: internal conflict arises when the current situation resonates with unresolved traumatic experiences of the past, and this is what can disrupt the therapist's professional stability.

In this context, the therapist's resistance appears as an unconscious defence mechanism aimed at avoiding the re-experiencing of pain associated with personal trauma. For example, a professional who has not processed his or her own experience of emotional abuse may tend to overidentify with the client or, conversely, avoid relevant topics due to the activation of basic emotional schemas and anxiety.

As noted by Lytvynenko and Tereshchenko (2024), in addition to the usual basic internal conflict, the descendants of transgenerational trauma survivors may develop a basic transgenerational conflict - an unconscious internal conflict that arises as a result of the unconscious transmission of survival and adaptation strategies after sudden, uncontrollable threats to the physical or social existence of ancestors who were unable to go through the process of grieving and processing these events. Particular attention should be paid to the phenomenon of transgenerational trauma, which, according to the Primal-We concept (*i.e., one of the four model dimensions*

of positive psychotherapy, describing the individual's relationship with their origin or primal community — a deep layer of experience shaped by the life philosophy, spiritual orientation, or worldview of primary caregivers and their family system. This dimension is not necessarily related to formal religiosity but reflects foundational attitudes toward meaning, purpose, and belonging that are later activated or challenged in the face of trauma), is transmitted from generation to generation not only through family narratives and social learning, but also through epigenetic mechanisms that affect neurobiological sensitivity to stress (Yehuda et al., 2015). In psychotherapeutic practice, this form of hereditary traumatisation can manifest unconsciously, in particular in the form of resistance, excessive empathy, reactive countertransference, or avoidance of certain topics (Danieli, 1985, 2015; Lytvynenko & Tereshchenko, 2024).

These mechanisms are activated when a therapist works with clients whose experiences resonate with their family's historical traumas: war, persecution, sexual violence, loss, deportation, or repression. In such cases, transgenerational conflicts can be disguised as current or basic conflicts, making both diagnosis and therapeutic intervention difficult. According to current research (Yehuda et al., 2015), the experience of severe trauma in parents or grandparents can change the level of stress hormones (in particular cortisol) in descendants, which creates increased emotional sensitivity, a tendency to hyperreactivity or, conversely, to emotional "freezing" in situations that remind of the primary trauma.

Psychotherapists who are not aware of their own intergenerational heritage may unconsciously transfer these reactions into their professional work. Awareness of transgenerational influence allows not only to reduce the risk of professional maladjustment, but also to turn one's own history into a source of deeper understanding and empathy. This expands the boundaries of professional ethics: the therapist works not only with the client's story, but also with the "shadow" of their own family, and such work requires responsibility, maturity, and a self-reflective position.

This process is accompanied by a tension between primary emotional needs (security, acceptance, contact) and secondary social attitudes (control, distance, adherence to a professional role), which leads to psychological disorganisation or somatic manifestations - psychosomatic symptoms, loss of meaning, professional burnout. In such cases, the symptom performs a compensatory function, temporarily maintaining internal balance, but at the cost of reducing the depth of contact with the client and professional efficiency.

In positive psychotherapy, these manifestations are seen not only as an obstacle but also as a potential resource for personal growth. The model of the "four areas of conflict and experience processing" (N. Peseschkian, 1987) allows us to localise resistance in the body, achievements, contacts, or fantasies.

We propose an adaptation of the model "Intrapersonal Space" (Dobiała, 2020) and the concept of "Protection from access to the content of the underlying conflict" (Tyshchenko, 2025) to illustrate the mechanisms of psychotherapeutic resistance that arises as a result of unprocessed personal trauma (Figure 4).

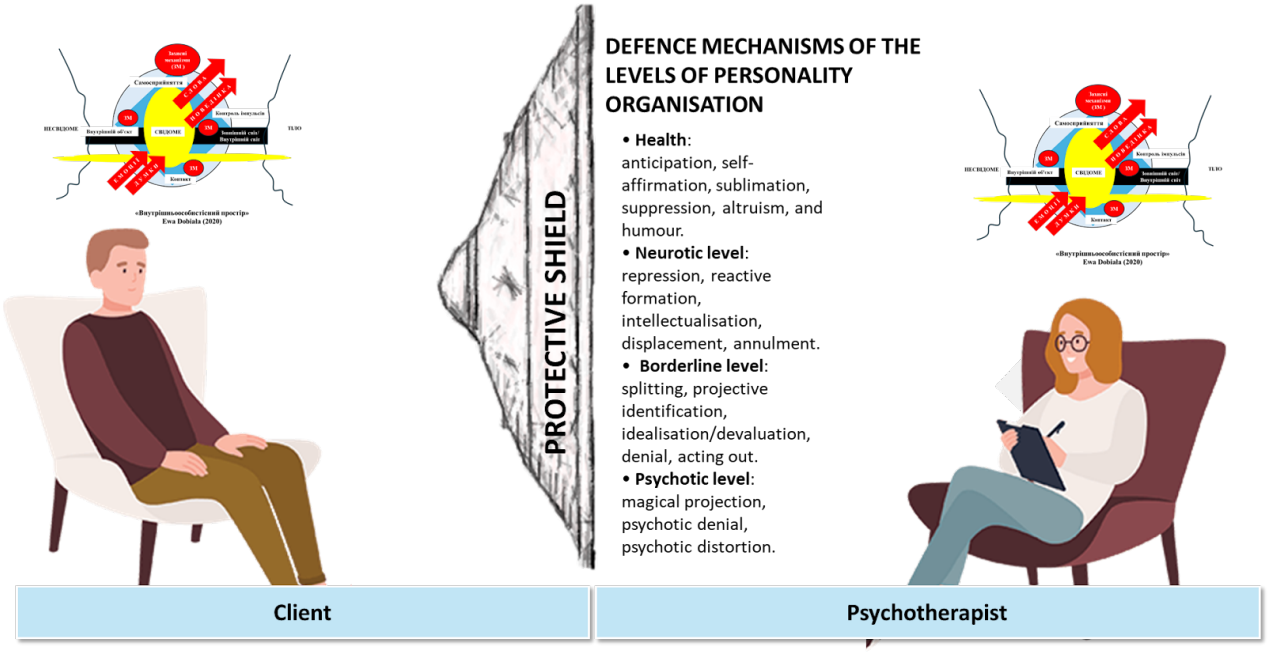

Figure 4. Protection against access to the therapist's unprocessed personal trauma

This diagram illustrates the defence mechanisms that both client and therapist can activate to block access to painful, unprocessed experiences. The centre depicts the intrapersonal space, a model proposed by Dobiala (2020) that reflects the interaction between the conscious and the unconscious, the internal object and the external world, behaviour and emotions, thinking and body. The key element of the model is a protective shield - a metaphor for an unconscious psychological "barrier" that prevents access to the traumatic core of the personality. This shield is supported by defence mechanisms of different levels of personality organisation, from mature to psychotic. The scheme emphasises that the psychotherapist, like the client, has a zone of unconscious experience, and if this experience is not integrated, defence mechanisms can be activated in response to a triggering situation, especially when working with traumatic topics. In this case, psychotherapeutic resistance is not a conscious choice, but rather an unconscious adaptive response aimed at preserving the integrity of the self. Therefore, the key task of the therapist is not to avoid these processes, but to be aware of them, to study the level of their manifestation, and to integrate their own traumatic experience through personal therapy, supervision, and regular reflective practice.

Thus, a psychotherapist's resistance to unprocessed trauma requires careful recognition and delicate work through supervision, own therapy, reflection, and positive interpretation. This not only prevents professional maladjustment, but also contributes to deepening personal maturity, expanding the ability to empathise and integrate traumatic experience within the professional identity.

3.4. Stigmatisation and social prejudices about trauma as factors of resistance to psychotherapy

Working with clients' traumatic experiences is accompanied by the influence of deeply rooted social attitudes and cultural norms that form a stigma around the topic of trauma itself. This stigma, regardless of the type of event experienced - sexual violence, loss of a loved one, war, or natural disaster - affects not only clients but also therapists. It can lead to resistance, personal conflict, anxiety, feelings of incompetence, or loss of professional identity.

Sexual violence is one of the most taboo topics in society. Widespread prejudices against victims (victimisation, sexual objectification, silent culture of shame) cause emotional stress for the therapist. This is especially true when the therapist has an unprocessed experience of similar trauma or faces an internal conflict between empathy and the need to maintain professional distance (Figley, 2002; Flood & Pease, 2009).

The loss of a loved one is another topic around which social taboos are formed. In a

culture that expects "quick recovery" or "not exaggerating grief", the therapist may have difficulty openly accepting the grieving client, especially if their own experience of loss has not yet been integrated. Unexpressed sadness, unlived longing, or forbidden feelings can be transformed into resistance - a loss of emotional presence, avoidance of the topic, or micro-alienation of the client (Herman, 2021).

Domestic violence, including emotional or physical abuse by a partner or parent, is often perceived by society as a "private matter" or "mutual guilt". This leads to insufficient coverage of the topic in professional training and causes therapists to struggle internally between their own beliefs, empathy for the victim, and expectations of neutrality.

The trauma of war (in civilian or military clients) is accompanied by a powerful patriotic or heroic discourse, which sometimes makes it difficult for the therapist to work with the client's real feelings of fear, helplessness, guilt, or loss. If the therapist has a history of combat experience or loss, they may unconsciously distance themselves, intellectualise, or avoid painful topics as a way of protecting themselves (Sprang et al., 2007).

The stigma of trauma from a natural disaster, pandemic, or accident - in such cases, clients often face humiliation or devaluation ("others have gone through the same thing and are not complaining"), which can create a hidden lack of recognition of the depth of someone else's pain. The absence of a culture of open discussion of mass grief can also lead to avoidance of such topics in sessions.

A therapist's internal conflict is formed as a result of the clash between their personal beliefs, social context, gender roles, cultural norms, and professional expectations. Such conflict can lead to unconscious resistance: avoidance of certain clients, superficial work, over-intellectualisation, or loss of the meaning of helping. This is especially true when the client's trauma resonates with the therapist's personal history or activates socially constructed biases.

The way out of this internal trap is to be aware of the influence of the social context on one's own reactions, to incorporate critical reflection, supervisory support, and to internalise the values of respect for the client's experience, regardless of its type. Stigma-free psychotherapy starts with a therapist who is able to recognise and work with the influence of social narratives on themselves.

Stigmatisation and social prejudices that underlie therapeutic resistance do not arise by chance - they are formed, consolidated, or transformed in the process of personal and professional development of a specialist. We propose to consider these processes through a three-stage psychodynamic model of concept formation that reflects the movement from uncritical assimilation to conscious choice.

1. In **the first stage,** concepts about trauma, violence, gender, or loss are learned from the social context as "truths" - for example, "it is the victim's fault" or "men are not victims".
2. At the **second stage** - differentiation - an internal conflict arises: the experience of working with real customers challenges these perceptions, causing doubt, shame, or resistance.
3. In the **third stage,** transformation, the therapist consciously rethinks previous ideas, adapting them to ethical standards, or (often unconsciously) leaves them in place, which maintains chronic resistance.

This model contributes to a deeper understanding of the causes of internal resistance and is a tool for self-reflection for the therapist. We suggest using it as an analytical framework, as shown in Table 2.

Table 2.
Three stages of psychodynamics of stigmatic beliefs in a specialist

Stage	***Description.***	***An example of a stigmatising belief***
1. Formation *(imitation)*	Stigma is learned as "truth" from authoritative sources (family, education, social environment), without critical evaluation.	"The victim is to blame", "men are not victims", "violence is shame".
2. Differentiation *(questioning and trying new perspectives)*	The psychotherapist notices an internal conflict between the learned stigma and the client's reality. Emotional tension and the need for reassessment arise.	"I can see that this client has really suffered, although I used to think that it was 'their own fault'"; "Perhaps men also experience violence, but I don't know how to work with them."
3. Transformation *(awareness and choice)*	The stigmatising concept is either consciously integrated with new content or replaced by a new one - more ethical, professional and empathetic.	"Violence can happen to anyone - my job is to support without judgement"; "I recognise my prejudices and am ready to work on them".

3.5. Religion and spirituality as support and challenge in trauma work

Religion and spirituality can be both a profound resource for healing and a source of secondary trauma or avoidance. For many people, faith becomes a support in times of loss, war, disaster or violence. However, spiritual beliefs sometimes take the form of psychological defences that make it impossible to live with and integrate painful experiences. In such cases, we speak of *spiritual bypassing* (Welwood, 1984) - when spiritual ideas or practices are used not to make sense of, but to bypass emotional truth. Pargament (2011) and Swinton (2001) describe the phenomenon *of false comforters* or *toxic religious messages* that may unconsciously deny, devalue or rationalise the experience of the victim

- "This is your trial" (denial of real suffering);
- "Forgive and you will be free" (putting spiritual values above safety);
- "He is also a child of God" (justification of the offender);
- "Carry your cross in silence" (coercion to self-sacrifice, silence).

Such concepts, although they may look benevolent, actually activate defence mechanisms (dissociation, intellectualisation, shame, guilt, false submission) and become an obstacle to the therapeutic process. To better understand the mechanism of influence of such beliefs, we propose to consider an adapted model of the "vicious circle of spiritual avoidance", as shown in Figure 5.

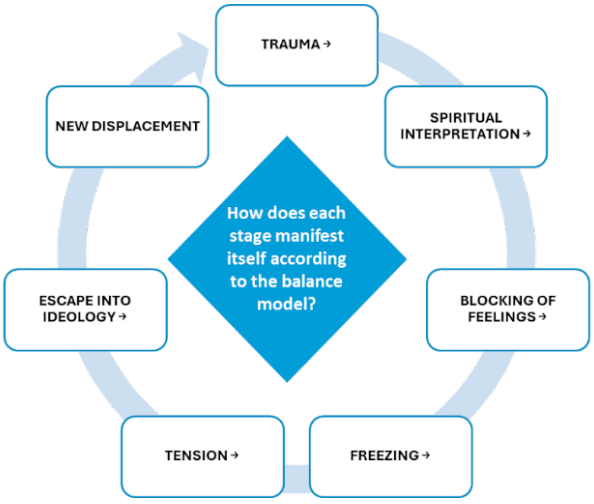

Figure 5. The cycle of the vicious circle of spiritual avoidance

As illustrated in Figure 4, the model illustrates how religious interpretations that do not take into account the psychological reality of trauma can block its integration:

1. A traumatic event (violence, loss, war, disaster) causes a strong emotional reaction - fear, anger, pain, powerlessness.
2. Instead of dwelling on these feelings, an immediate spiritual interpretation is activated without affective processing: "This is God's plan", "endure, you will be rewarded", "you cannot complain".
3. These formulas act as a defence mechanism that blocks or prohibits the expression of feelings. Anger, shame, horror are not recognised as acceptable or spiritually permissible.
4. Emotions are supplanted, and the body and psyche remain in a state of frozenness - "the trauma did not happen", although its impact remains.
5. At the unconscious level, anxiety, guilt or shame accumulate, which have no way out and only increase internal tension.
6. This strengthens the attachment to religious ideology as a way to avoid pain - faith begins to serve as avoidance rather than resistance.
7. The vicious circle closes: new suffering is again interpreted as a "higher will", not lived, not comprehended, but shunted away.

As a result, the symptoms do not disappear, but are transformed into psychosomatics, rigidity, burnout, or even therapeutic resistance in the specialist himself.

To gain a deeper understanding of how religious beliefs influence the experience of trauma, it is important to consider them not only as elements of intrapsychic defence mechanisms, but also within the broader context of relational patterns. In this regard, the relationship model proposed by Kirillov (2019) offers a valuable framework. Traumatic experiences — such as war, sexual violence, or profound loss — often lead to a collapse of foundational trust: in oneself, in others, in the world, and even in higher powers. These relational ruptures may be particularly profound when existential beliefs — especially those shaped early in life by familial, cultural, and spiritual influences — remain unexamined or rigid. For instance, if the concept of a punishing deity ("God sent this to me as punishment") persists unchallenged, there is a heightened risk of entrapment in feelings of guilt, shame, or self-blame.

When working with spiritual beliefs, the therapist must be sensitive to each of these areas. By inviting the client into a dialogue across all four relational dimensions — the **"I" dimension** (one's relationship with oneself, formed through early experiences of self-worth, trust, and autonomy), the **"You" dimension** (the internalised model of intimate partnerships, typically based on parental dynamics), the **"We" dimension** (the individual's patterns of interaction with society, shaped by how their caregivers related to the social world), and the **"Origin" or "Primal-We" dimension** (the foundational connection to one's cultural, religious, or existential heritage, including inherited views on meaning, purpose, and spirituality) — the therapist supports a comprehensive reconstruction of the client's internal world. Importantly, the concepts associated with the 'Primal-We' dimension are typically among the earliest to form — shaped by familial, cultural, and religious influences — and are also the most resistant to change. Given their central role in shaping an individual's existential framework, any attempt at their revision requires considerable time and therapeutic sensitivity.

This model, grounded in the concept of early "forms of love" and intergenerational role models, enables a deep integration of pain, restoring the individual's capacity for love, orientation, and coherence. In this process, religiosity no longer functions as a rigid psychological defence but may be reinterpreted as a flexible internal resource — a source of continuity, existential grounding, and healing potential.

It is important to maintain a balance between respect for the client's beliefs and the therapeutic task of integrating traumatic experiences. Religion should not become a barrier to expressing pain, protest or anger. In working with clients who have experienced sexual violence, loss of relatives, war or disasters, the psychotherapist should:

- recognise when spiritual ideology is a defence mechanism;
- help the client to realise what emotions have not been lived;

- to invite a balance between faith and affective truth.

In this way, spirituality can become a resource again, but only after the trauma has been given space for its recognition, comprehension and transformation.

3.6. Ethical and moral dilemmas

When working with trauma, especially in cases of sexual abuse, loss, war, or disaster, the therapist inevitably faces ethical and moral dilemmas. These situations arise when a professional's personal beliefs or emotional response conflict with professional standards or the needs of the client.

One of the most acute examples is the dilemma of confidentiality versus the safety of others. Informing a client about a possible threat to themselves or others creates a tension between the ethical obligation to maintain the client's trust and the moral obligation to protect life and safety. This is especially true when working with survivors of sexual violence or with clients who are perpetrators themselves. As noted by the American Psychological Association (APA, 2017) and the World Association for Positive and Transcultural Psychotherapy (WAPP), the principle of confidentiality has limits, especially in situations where there is a risk of harm. In times of war, this tension is exacerbated: as Tyshchenko (2025) notes, compliance with ethical standards of psychotherapy acquires new dimensions when a specialist acts in conditions of moral turbulence and general vulnerability.

Ethical and moral dilemmas are also an important factor in therapists' refusal to work with cases of sexual violence. This is due not only to the need to violate confidentiality to protect others, but also to a deeper internal conflict. As Knight (2013), fear of emotional overwhelm and doubts about their own competence can make professionals avoid this topic, especially when working with aggressive clients or those with co-occurring mental disorders. According to Tyshchenko (2024), aggression bias as a form of unconscious defence can also play a significant role in shaping resistance, making it difficult to be ethically neutral in therapy with clients who display aggressive traits (Tyshchenko, 2024). In such situations, the dilemma is to balance caring for yourself as a professional and fulfilling your professional duty.

In addition, the stigma of sexual violence and societal prejudice (Burt, 1980; Herman, 2021) can cause therapists to feel conflicted about their professional role, especially if they have their own experience of trauma or if their conceptions are shaped by cultural norms that taboo violence, sexuality, or corporeality.

This range of problems also includes ethical conflicts that arise when working with an abuser while actively empathising with the victim - the therapist may face emotional disgust, anger or fear, which contradict their professional duty to remain neutral and empathetic towards each client.

We offer the following approaches to dealing with an ethical dilemma:

- Engage in supervision and collegial discussions as an ethical practice and a space for self-reflection.
- Refer to the profession's ethical codes (WAPP, APA, EAP, USP, etc.) as an objective framework for decision-making.
- Identify and distinguish between ethical, moral and emotional reactions: "How do I feel?", "What does my professional duty say?", "What does the situation require for safety?"
- Make visible the biases and stereotypes that influence decisions: as noted above, they can be transgenerationally inherited or socially imposed.
- Maintain a balance between client care and self-care as an important part of ethical practice.

Thus, ethical and moral dilemmas are not a weakness, but a professional challenge that requires maturity, ethical competence, and the courage to be honest with oneself. Their timely recognition and processing is the key not only to effective client care, but also to the professional endurance of the psychotherapist.

3.7. Difficulties of transfer and counter-transfer

Transference and countertransference are key psychodynamic processes in psychotherapy, especially when working with clients who have experienced trauma. In the context of psychotraumatic experiences, these phenomena become especially complex and intense, activating unconscious reactions of both the client and the therapist.

The therapist's unprocessed personal trauma can significantly affect the course of the therapeutic process through countertransference. This manifests itself in the form of excessive empathy, avoidance of certain topics, emotional distancing, or even repetition of the client's destructive patterns (Freud, 1912; Klein, 1998; Ogden, 1997). The lack of reflection on countertransference can violate professional neutrality and reduce the effectiveness of therapy. That is why regular supervision and personal therapy are essential for maintaining professional functioning (Gabbard, 2001;; Herman, 2021; Hinshelwood, 1989).

According to Tyshchenko (2025), working with trauma is accompanied not only by emotional but also by physiological activation in the therapist, which can manifest itself in the form of fatigue, somatic symptoms, or unconscious resistance. In this context, it is important to view countertransference not as a problem, but as a tool that provides access to the client's repressed experiences. This approach coincides with the position of B. van der Kolk (2014), who emphasises the bodily dimension of traumatic memory and the importance of bodily sensitivity in the therapy process.

When working with trauma of any origin - sexual, emotional, war, interpersonal, or transgenerational - it is important to consider that transference can take on regressive or confusing forms. The client may simultaneously see the therapist as a "saviour" and an "aggressor", which makes it difficult to build trust (Herman, 2021). In such cases, the therapist may experience conflicting feelings - from compassion to disgust, from admiration to fear - and these reactions are valuable signals for psychodynamic analysis.

According to positive psychotherapy (Henrichs & Hum, 2020; Kirillov, 2019; N. Peseschkian, 1987;), transference is the spontaneous reproduction of significant emotions from the past in a therapeutic situation, and countertransference is the therapist's emotional reaction that arises from his or her own experience. Work with these phenomena is carried out through the three stages of psychodynamics: attachment, differentiation, and detachment. In the attachment stage, the therapist serves as a "container" for the client's affects. At the stage of differentiation, the therapist helps to recognise and verbalise these feelings. At the stage of detachment, the therapist supports the client's autonomy in the new experience of responding (Dobiala, 2020; Henrichs & Hum, 2020).

In addition, difficulties arise when the client reproduces the experience of violent or toxic patterns in the relationship with the therapist. For example, in the process of countertransference, the therapist may experience anger, helplessness, shame, or defensive detachment. Sometimes, countertransference may involve identification with the aggressor or victim, leading to a loss of neutrality. In extreme cases, the therapist may encounter the phenomenon of "double transference", when the patient simultaneously identifies with both the victim and the aggressor. In this context, it is worth mentioning the classification of Racker (2014), who distinguished between concordant countertransference - when the therapist identifies with the patient's internal state - and complementary countertransference - when the therapist unconsciously assumes the role of an object from the client's internal world, in particular the aggressor or victim. This distinction helps to better understand the position from which the therapist responds to the client and how this affects the dynamics of the relationship in the session.

Situations are particularly difficult when the patient reports their own aggressive or violent impulses or admits to behaviour associated with violence. This can cause the therapist to feel anger, judgement, disgust, or moral conflict, making it difficult to continue the therapeutic process. However, it is the awareness of these feelings and their processing within supervision that allows the therapist to maintain a professional stance and help the client integrate these aspects of themselves without re-traumatising them.

To prevent the negative impact of unprocessed trauma, it is important to implement the following practices:

- Personal therapy with a focus on working with one's own trauma. Metaphorically, this can be thought of as a "key" that opens the way to a deeper understanding of the client at a moment of therapeutic "stagnation", when the body tenses and the consciousness seems to "stop". In such cases, we

recommend using the Balance Model of reflection.
- The Balance Model can be useful for self-diagnosis: Where am I currently at as a therapist? What does this situation remind me of from my own underlying conflict? Where and when have I experienced this before?
- Supervision as a tool for identifying repetitive reactions, blind spots and potential resistance.
- Reflective practice of self-observation of one's own emotions, bodily reactions, and perceptions of the client.
- Psychoeducation on neurobiological, cultural and intergenerational aspects of trauma as a necessary component of professional maturity.

Conclusions

The article examines the phenomenon of psychotherapist resistance in trauma work as a complex internal dynamic that encompasses personal, professional, cultural and ethical dimensions. The results obtained allow us to draw the following conclusions:

Psychotherapist resistance is not an exceptional situation, but a natural reaction to contact with the client's traumatic experience, especially if this experience touches on unconscious or unprocessed areas of the professional. It can manifest itself in the form of emotional loss of presence, distancing, pain overload, avoidance, or identification.

The phenomenon of resistance is closely related to secondary traumatisation, emotional burnout and transference, which requires not only clinical analysis but also systemic support through supervision, psychoeducation, regular reflective practice and personal therapy.

Positive psychotherapy offers a constructive approach to understanding resistance as a potential resource that indicates deep conflicts, not just as an obstacle. The use of the Balance Model, the five stages of work, and the concepts of "actual" and "underlying" conflict allows not only to interpret resistance but also to integrate it into the process of professional development.

Social and cultural factors, such as the stigma of trauma, religious beliefs, and ethical dilemmas, influence the therapist's unconscious reactions, forming resistance to topics that are taboo or difficult for personal acceptance. That is why it is important to recognise the socially conditioned dimension of resistance and work with it through the prism of critical consciousness.

The presence of personal or transgenerational trauma in the psychotherapist can unconsciously activate resistance in working with certain topics or types of clients. This requires additional attention to one's own history, projective identification mechanisms, and bodily reactions.

Awareness of therapist resistance is a professional duty, not a weakness. It is a key step on the way to a mature therapeutic stance capable of withstanding pain, doubt, aggression, and ambivalence - both one's own and the client's.

In conclusion, the psychotherapist's resistance in working with trauma should be seen as a mirror of internal conflicts, a point of entry into deeper layers of professional identity, and a space for growth - personal, ethical, and clinical.

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