Bodily Countertransference

CRAVING INTERPRETATION: A CASE OF SOMATIC COUNTERTRANSFERENCE

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Contemporary psychoanalysis views the countertransference as equally important to the therapeutic endeavour as its counterpart, the transference. This paper focuses on a particular kind of countertransference phenomena: those which are bodily in form and perceivable to the patient. It begins with a brief rehearsal of some of the fundamental psychoanalytic principles related to bodily symptoms, and then reviews the developments and changes that have occurred in the understanding of the concept of countertransference. The focus then shifts to theoretical developments around somatic countertransference in particular, and the division seen in the literature between authors who locate the source of the phenomenon of somatic countertransference in the patient’s unconscious, and those who locate it in the therapist. The paper will argue that exploring the uniqueness and specificity of the therapeutic dyad will reveal important information about the dynamics at work in the therapy. A clinical example illustrates the specificity of the form that a somatic countertransference takes in a particular therapy. It then proposes that in order to make sense of the rich information that this unique response provides, the therapist must mentalize and make meaning of her particular somatic experience by way of a therapeutic analysis of reverie.

KEY WORDS: SOMATIC COUNTERTRANSFERENCE, COUNTERTRANSFERENCE, BORBORYGMI, PHYSICAL RESPONSE, VISIBLE COUNTERTRANSFERENCE, AUDIBLE COUNTERTRANSFERENCE

INTRODUCTION

This paper is located within the context of attempting to ‘mind’ what the analyst’s body can bring to a therapeutic process. The paper focuses on moments in the therapy when the analyst’s body enters the room in ways that cannot be controlled by the analyst and on how engaging with these moments may lead to therapeutic gains. The paper concentrates specifically on those countercountertransferential bodily phenomena which are perceivable by the patient.

In contemporary psychoanalysis, countertransference is seen as being equally fundamental to the analytic endeavour as its complementary process, the transference (Carlson, 2009). However, somatic countertransferences receive less attention than more common, ‘mental’ forms of countertransference such as the analyst’s thoughts and fantasies. It is likely that this is because countercountertransferential manifestations in the form of thoughts or fantasies are in the same register (i.e. language) as that in which therapy takes place.

Understanding somatic countertransferences can result in useful therapeutic gains, but these phenomena can often be difficult to deal with and complex to understand. The mere fact that these are bodily reactions may make them less controllable, less easy to disguise and less easy to interpret than other forms of countertransference. When these reactions are perceived by the patient they may become even more alarming to the therapist as they reveal material about the therapist before the therapist has a chance to interpret and understand it herself.

On reading the literature on somatic countertransference, it is easy for one to form the impression that ‘psychosomatic’ events in the analyst are commonly seen as pathological and problematic failures of mentalization. This pejorative view is unhelpful and does not encourage these experiences to be considered and understood. The paper attempts to challenge that view and instead argues for the clinical usefulness of paying attention to bodily countertransference reactions, particularly those perceivable to the patient, in order to reveal the psychodynamics at work in the particular dyad. The paper begins by briefly framing the theoretical context in which it is positioned, and then makes use of a case example in order to illustrate the points being made.

THEORETICAL CONTEXT

In order to place this paper in a theoretical context, it is important to briefly review two areas of psychoanalytic literature. The first of these is the psychopathology behind psychosomatic responses, and the second is the literature regarding somatic countertransferences.

Psychosomatic Responses

The earliest understandings of symptom formation and the interpretation of those symptoms were generated by Freud’s work on hysteria. This work understood that...
mental conflict could be expressed in bodily terms (Breuer & Freud, 1893; Freud, 1912b). Hysterical symptoms were treated in the mode of language using interpretations which were intended to lift the repression of the traumatic memories which lay behind the symptoms, and to transform these, and their related wishes, from physical symptoms into psychological objects. The aim of this treatment was for the analyst to aid the patient to develop insight into the symptom and into the unconscious meaning behind its form (Freud, 1905). Theorists working in the field of psychosoma after Freud expanded on this idea and proposed new understandings of psychosoma.

Pierre Marty (1968) coined the term ‘mentalization’ following his work with somatising patients whom he observed to commonly lack psychic representations and psychic processing, and to present as though their minds were empty. He understood mentalization as a process of working mentally to interpret and respond to the body’s demands.

The concept of mentalization is also used extensively in the area of attachment theory where it is conceived of as an interpersonal mental process in which an individual perceives and interprets their own and others’ behaviour (Fonagy, Gergley, Jurist & Target, 2004). Of particular importance here is the general understanding that mentalizing is dependent not only on resonance and imitation of the states of others, but also on the knowledge of one’s own body. Indeed, most theorists working in the field of mentalization emphasize that mentalization begins in the body at the point when an individual begins to engage with, and understand, their drives and affects (Allen, Fonagy & Bateman, 2008; Fonagy et al., 2004; Fonagy & Target, 2007).

It is now generally accepted that the problem of psychosoma is relate to a failure of the mental apparatus to work over or bind somatic excitations, and the result is that phenomena that are unmentalized remain unconscious and are expressed by the language of the body rather than the language of the mind (Gottlieb, 2013), and should the ability to mentalize be compromised, it is likely that higher order mental processes might also fall and psychosomatic processes may thus develop.

I am suggesting that, when the countertransference is diagnostic, similar processes may be at work and that therapists then need to ‘mind’ their own body by uncovering and interpreting the meaning behind their own physical response. In other words, there should be a diagnostic, interpretive dimension to the psychoanalytic practice of making use of somatic countertransferences in the therapy room.

Somatic Countertransference

While there is a substantial body of literature on countertransference generally, there is less written about somatic countertransference in particular. The area of countertransference is theoretically complex and its development is tracked and commented on by authors including Gabbard (1995, 2001), Richards (1989), Smith (2000) and Zachrisson (2009). The concept has undergone two fundamental shifts since it was first introduced by Freud (1910) where it was understood as the analyst’s transference to the patient’s transference and viewed as a difficulty which analysts should do their best to overcome. Following the work of Winnicott (1958), Little (1951), Racker (1957, 1968) and particularly Heimann’s (1950) paper ‘On countertransference’, the concept of countertransference has now come to include all the feelings and reactions that the analyst experiences while in relation to a patient (Jacobs, 1999; Lazar Smith, 1990; Young, 1995). This wider view of the concept further suggests that all countertransference reactions can be used in order to gain a deeper understanding of the patient, and sees countertransference as the analysand’s reaction to the patient’s unconscious dynamics and how these manifest in the therapy, rather than being merely a reflection of the analyst’s own internal, unconscious material (Epstein & Feiner, 1979; Zachrisson, 2009). Most importantly, this widely accepted, broader understanding no longer sees countertransference as problematic and something to be avoided, but rather as a helpful tool to be added to the therapist’s repertoire (Epstein & Feiner, 1979; Zachrisson, 2009).

The second important shift is as a result of the more contemporary view of countertransference which does not look for the origin of a countertransference in either the therapist or the patient alone, but instead understands that it is the unique material that develops in that particular therapeutic dyad which results in the specific countertransference manifestation. Gabbard (1995, 2001) describes this understanding of countertransference as the patient drawing the therapist into playing a role that reflects the patient’s internal world, but that the specific dimensions of that role are coloured by the therapist’s own life history.

It is clear that the first of these shifts usefully extended the concept from its original form which was too narrow, and facilitated that countertransference became an irreplaceable tool for the analyst. It is important, however, that this expansion not be made so broad that, by including all the analyst’s conscious and unconscious material as well as all aspects of their personality, the concept is rendered meaningless (Sandler, Dare & Holder, 1992). In order to strike this balance, the useful definition of countertransference by Sandler et al. (1992) is used here – emotionally (and in this paper, specifically somatic) based responses which particular individual qualities of the patient arouse in the analyst.

Despite the various definitions and understandings of countertransference, one point which is not disputed is that it is essential that the analyst detect and name the countertransference (even if only to herself) in order for the clinical endeavour to progress effectively (Schwaber, 1992). Any concern about somatic countertransference in particular is rooted in the general moves in the acceptance of countertransference generally as these moves have allowed for an interest in the analyst’s responses to the patient as well as the development of tools to make sense of these responses.

Much of the theoretical writing that does exist on somatic countertransference seems to be divided into two categories: the first category is concerned with the kind of patients who are likely to elicit somatic countertransferences, while the second explores the kinds of traits, defences and personal histories that might make it more likely for an analyst to experience somatic countertransferences.

Authors who locate the source of a somatic countertransference in the patient include McLaughlin and Samuels, who focused their writings on the types of patients...
who are likely to produce somatic countertransferences. McLaughlin (1975) identified two types of patients: the first is patients who use defences that control and dull any emotion they deal with, while the second includes borderline and psychotic patients.

Following McLaughlin's work, Samuels (1985) conducted empirical research on somatic countertransference. His results also situated the source of the countertransference in the patient. Samuels's research noted that patients who presented with instinctual problems, such as difficulties regarding sex, aggression or eating, were more likely to evoke a physical countertransference (Samuels, 1985).

Focusing particularly on countertransference feelings of hunger, Greene (2001) suggests that hunger in the therapist generally represents deprivation that the patient is beginning to explore, and that the deprivation is resonating with a deprived place in the therapist's own history (Greene, 2001). Jacobs (1973) and Stone (2006) focused their attention on researching what it is about the therapist that makes it more likely that he or she would experience countertransference in a somatic form. Jacobs proposed three circumstances which might result in the countertransference taking a physical form: firstly, when the patient's material revives similar past physical experiences in the therapist; secondly, if a therapist is consistently faced with material that relates to highly conflictual bodily experiences; and thirdly, if the therapist is not able to experience bodily countertransference reactions in a way that is personally meaningful (Jacobs, 1973). What Jacobs highlights is the importance of the analyst's own physical level, thoughts and feelings remaining in the unconscious (Stone, 2006).

The more recent work of Stone (2006) mapped the Myers–Briggs Type Indicator personality characteristics of analysts who are likely to experience bodily countertransferences and saw a high proportion of therapists with an introverted sensing or sensing judgment, in particular, as being more prone to bodily countertransference reactions (Stone, 2006).

Off interest in this paper are the particular issues that arise in the relationship when the therapist does not have the freedom to express their feelings and the impact of this on the patient. Stone (2006) identifies the importance of the therapist's own history in understanding countertransference reactions and the role of the therapist's unique language style in the development of these reactions. Stone (2006) suggests that the therapist's unique language style is particularly important in the development of countertransference reactions and that understanding this language style is crucial for the therapist to be able to work with these reactions in a meaningful way (Stone, 2006).

What the groupings of literature discussed here (i.e., locating the source of the somatic countertransference in the patient or the therapist) have in common is that they seem to aim at developing a greater understanding of how the concept of countertransference needs to be adopted into clinical practice. It is widely accepted that countertransference reactions should be worked with by both the therapist and the patient, and that this work is essential for the therapeutic process to be effective (Stone, 2006).
Craving Interpretation: A Case of Somatic Countertransference

more visible to the patient. The therapist should be vigilant for such events so that if they bring new material to light when the patient notices the physical response (as it did in the case of Ann which is discussed below) this can be worked with and made use of. When the as yet unprocessed material of the therapist is brought into the room, it is incumbent on the therapist to make use of all the tools available (particularly that of reverie) in order to reveal the meaning of such a response as deeply and thoroughly as possible to themselves first, and then to apply that understanding to that particular therapist’s dynamics. These situations may add pressure on the therapist to maintain their analytic stance and not engage in an enactment, but even if slips in these areas do occur, thoughtful and careful analytic work can reveal those underlying dynamics which crave interpretation.

A CLINICAL EXAMPLE

In order to demonstrate the complexities involved in uncovering the meaning behind a physical response to a particular patient, I will discuss a case in which the usefulness of interpreting and understanding the form that the physical countertransference takes was clear. The patient in question (whom I will call Ann) attended twice-weekly face-to-face psychotherapy, presented herself as a kind and sensitive person who always put others first. She was softly spoken, friendly and obliging. Her anorexia was entrenched, and she would severely restrict her eating, but would also taunt herself by exposing herself to food that she would not allow herself to eat, like standing in a bakery and smelling meat pies cooking. She would feel great triumph when she was able to walk out of the store and deny herself what she was craving.

Ann would always arrive for her sessions a few minutes early, and would frequently comment on whether I called her from the waiting room on time (which she measured by the second hand reaching the ‘12’ on the clock in the waiting room), or if I was a few moments early or late. While she presented this in her ‘sweet’ way by saying that I was ‘spot on so much of the time’, she was a little triumphant if I called her into the session a moment early or late.

During many sessions with Ann, I would experience sudden and severe hunger. My stomach would rumble loudly, to the point that the patient would notice and pull a disapproving face as if to express her disgust at my apparent desire to eat. What was particularly noteworthy was that on these occasions I would crave a very specific type of pizza with a number of meat toppings, and I sometimes had a visual image which was like a hallucinatory gratification of the pizza floating between us just out of my reach. This type of pizza was not something that I would ordinarily eat and, significantly, the patient had stopped eating meat a number of years before in order to restrict her calorific intake.

I became aware of the depth of the transference-countertransference dynamics and how I enacted them, when I invited a friend, with whom I have a competitive relationship, to join me for a pizza. She said that she was expecting my call as I called every Monday to suggest that we go for a pizza. Mondays were the days on which Ann was the last patient of the day.

Of particular importance here were the frequency and intensity of the stomach rumbling (known as borborygmi) (Da Silva, 1990; King, 2011) and the accompanying severe hunger and visual image of the pizza. I did not have any of these ‘symptoms’ with any of my other patients, even those that I saw at a similar time of day or who also restricted their food intake. This is similar to an experience described by Lombardi (2002) during his treatment of an anorexic patient and which he understood as the mind trying to free itself from bodily sensations.

INTERPRETING THE SOMATIC COUNTERTRANSFERENCE

My stomach rumbled frequently in the sessions with Ann, and she always pulled a disgusted face in response, and would sometimes comment on the sound. She would (unconvincingly) attempt to apologize for making me work late and for keeping me from the food that I obviously desired. Interpretations were met with a shrug and smile, but I was left with the strong sense that her comments and gestures indirectly meant ‘you poor mortal having these base, physical needs’.

This seemed to be a part of her transference which was superficially so sweet, polite and self-deprecating, but which certainly seemed to have a sting in the tail.

Despite working in a different paradigm to the one described in this paper, some of the work of Bromberg is useful in understanding this case. My physical response might well have been a projective identification with Ann’s dissociated desire for food in line with Bromberg’s (2001) suggestion that eating disordered patients regulate their desire by means of dissociation. Commenting on my desire and completely disowning any of her own is more evidence of her dissociation.

It was after I had called my friend and invited her for pizza yet again, and she had commented that I did that regularly on a Monday night, that I developed further awareness of the dynamics at work. After eating the entire pizza, the craving was satisfied, but I felt over full, guilty and disgusted with myself and I was aware of the very clear thought that ‘Ann would never have eaten that’. The thoughts and feelings in that moment were similar to Bromberg’s (2003b) description of something related to this patient leaving me feeling a bit ‘off’. Reflecting further allowed me to become more aware of the idea of ‘Ann versus me’. I had had the physical response, the craving and visual image similar to an hallucination of the pizza, however, the hallucination was not satisfactory and therefore needed to be enacted, and so I had allowed myself to satisfy the wish, but all of that had occurred against the backdrop of how that was in contrast to the way in which Ann would engage with the world. This experience echoed Renik’s (1993) idea that the analyst often develops an awareness of their countertransference only after an enactment, and Devereux’s (2006) emphasis on the importance or deciphering and working through the enactment.

In the following sessions, when this somatic response occurred, my reverie contained all the different factors which were at work in this transference-countertransference dynamic. These included the time at which the response occurred.
it was always on Monday, the day when Ann was my last appointment of the day; the food I craved was a high calorie, high fat meal which I knew I would eat because it made me feel better. I became aware of a paradox in the way I was acting. On one hand, I was trying to mitigate my failure by making my friend complicit in it, in order to feel less defeated by my patient and envied of her iron will. On the other hand, I thought that Ann would never have eaten the pizza.

After reflecting on these elements, and following my reverie, what emerged was the competition that Ann was setting up between herself and me. I knew myself to be compelled to do "difficult" things and to enjoy the process of overcoming them. However, the competitive nature of the relationship with Ann was different. It was more than just a challenge to me. It was also a reflection of the competitive nature of Ann's life and her relationship with her environment. I became aware of this and realized that the physical response was occurring in relation to her. Chapter 3 of "The Body in Mind" by Da Silva (1990) and King (2011) has written about the physical response of "borborygmi" specifically. This literature establishes the idea of gastro-intestinal movements as having a strongly metaphorical dimension and thus the authors suggest that...
**Craving Interpretation: A Case of Somatic Countertransference**

Karen Gubb

They hold a psychic meaning and, consequently, link body and mind. Instinctual in the case of Ann, it was clear that the particular understanding of gastro-intestinal responses allowed her to enter the site at which her pathology (anorexia) played itself out and was evidence of the desire that she dissociated herself from. Thus the analyst's somatic countertransference was a clue to the final understanding, but only the vehicle with which to reach that understanding.

Da Silva (1990) makes the point that when borborygmi occur in the analyst, it is a signal that the patient's conflict has resonated at a point of sensitivity within the analyst. Since my sensitivity is not related to food, it meant that the physical response was pointing to something else. This highlights the complexity of the relationship between the generalized understanding of the analysand and the specific responses of the analyst. In this case my borborygmi were accompanied by a severe hunger as well as the visual hallucination of the object that my hunger craved. The image of the pizza that appeared when I was hungry was not a wish for food itself, but rather the visual hallmark of my hunger. There is a common link within the image of the pizza and the sensate experience of hunger, but it is not clear how this sensation is translated from the physical to the mental. Only by examining the way in which the pizza satisfied the hunger in my mind, we can begin to interpret the physical responses as a manifestation of the patient's conflict.

**Second point made by Ogden (Ogden, 1994a, 1996b, 1997a)** which was helpful here was that the patient's physical response to the food was not simply a hunger, but rather a way of expressing internal conflicts. In this way, Ogden's writings on reverie were useful in developing an understanding of what was at work in this case. Four points were of particular interest: the role of reverie, the importance of the physical response, the objectified nature of the desire, and the analyst's role in interpretation. Ogden's (1997a, 1994a) third important point is that the responses which make up the reverie of the analyst are not just simply the analyst's own unresolved conflicts, current distresses, physical state or personality. Every situation experienced by the analyst is framed differently in the face of each patient and thus becomes a different analytic object.

Despite the volume of literature that discusses countertransference generally, there is relatively little written on the technique of exactly how to interpret the physical responses. Ogden (1994a) discusses the importance of reverie and the role of the analyst in interpreting the patient's physical responses. The work of Ogden (1997a, 1994a) is significant in that regard for this paper as his examples do not only explain the role of reverie in the analyst's interpretation, but also discuss the role of the analyst's physical responses. Ogden (1994a) argues that the analyst's physical responses are an important part of the analytic process and must be integrated into the interpretation. Ogden (1997a) also discusses the importance of reverie in the interpretation of the patient's physical responses.

The second point made by Ogden (Ogden, 1994a, 1996b, 1997a) which was helpful here is that the content of a reverie needs to be interpreted and understood. Ogden's interpretation of the patient's physical responses is not simply a matter of identifying the object of the desire, but rather the way in which the analyst's own physical response is translated from the conscious to the unconscious mind. Ogden's (1997a) third important point is that the responses which make up the reverie of the analyst are not just simply the analyst's own unresolved conflicts, current disturbances, physical state or personality. Every situation experienced by the analyst is framed differently in the face of each patient and thus becomes a different analytic object.

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layer of difficulty is added to managing somatic countertransferences when the somatic responses are perceivable to the patient, whether it be visually (e.g. tears or blushing) or audibly as in the case of borborygmi. The fact that the patient becomes aware of these physical responses in the therapist may have unanticipated consequences.

I am in agreement with Ogden’s (1994b) view that not every thought or feeling that an analyst has when with a patient is countertransference. There are times when a therapist may respond somatically to a patient, and where it is immediately clear to the therapist what the somatic response means. For example, a therapist may get tears in their eyes when they are told a sad story that reminds them of similar pain or loss in their own life. While these responses are of course important, they often occur at the level of the ego and are likely to manifestations of sympathy or identification. They do not therefore require sustained interpretive activity on the part of the therapist. When responses such as these occur, the therapist may be required to acknowledge their response, and it is clearly almost always important to pay attention to and interpret the patient’s reaction to the analyst’s physical responses. For example, a patient may feel comforted and validated by their therapist’s tears, or may become irritated or angry if they feel that it is now their responsibility to comfort the therapist. This material then becomes grist for the therapeutic mill. In this type of physical response it is the content of the material that moves the analyst to ‘ordinary’ affects like sympathy or identification, where, even if the intensity is determined by the therapist’s history, the extent to which this is a countertransferenceal response might be questioned and debated in the sense that it does not have a disguised, unconscious component. It is also likely that the same event being narrated by any other patient in conjunction with the analyst’s history would have produced the same effect.

The distinction being made here is one that is based on the therapist’s own intuition: while some somatic responses might need to be talked about with the patient, others immediately call for interpretation before they can be used therapeutically because their meaning is still unconscious and therefore not immediately available to the analyst. Everything that the analyst experiences in relation to the patient in the therapy room is relevant and potentially useful, but there is a fundamental distinction between that which only requires further reflection from that which requires interpretation.

What is of interest in this paper is the type of strong somatic countertransference reaction whose meaning is not immediately clear to the therapist and which is perceivable to the patient. The presence of these physical manifestations in their undeniable bodily form is not easily disguised from the patient by the therapist and are therefore more uncontrollable in their visibility or audibility than other forms of countertransference (such as affect or fantasy). They therefore bring something into the therapeutic space of the dyad which may need to be explored before the therapist develops an understanding of what the response might mean and in what way it might a reflection of therapeutic dynamics.

In these instances the therapist’s response immediately becomes a shared ‘analytic object’ (Ogden, 1997a). By contrast, countertransference reactions which occur in the domain of thought or fantasy can be kept from the patient and remain in the therapist’s revere until they have been unpacked and understood and the therapist can then make use of the information they reveal in the therapeutic process. In the case of Ann, it was the particular way in which she perceived and commented on my borborygmi which highlighted and brought the countertransference-countertransference dynamics to the fore, and made it a part of the dyad even before its meaning had been fully interpreted.

In the long run, the information it provided was crucial for the progression of the treatment and provided access to the highly beneficial material, but did require an active process of interpretation by the therapist first.

CONCLUSION

This paper contributes to how it is possible to think about and make use of somatic countertransferences. Since these responses occur in the physical domain, they require an additional layer of interpretation to other forms of countertransference. The form that the countertransference takes provides hints and clues to what the dynamics at work are, but it is important that the therapist understand these thoroughly and in the context of the particular dyad, since interpreting them simply at the general level may lead to simplistic understandings of their meaning. While it can be argued that some of this understanding would obviously apply to countertransference generally, somatic countertransferences need particular attention and focus, and once this has occurred and the underlying unconscious material has been understood the wider implications for the therapy will be exposed. ‘Minding’ the body of the analyst in this way may reveal important aspects of the dynamics at work in a particular therapy.

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NOTE

1. While there is a long history of psychoanalytic psychotherapy in South Africa, it has only been possible to train as a psychoanalyst and receive psychoanalytic treatment very recently. The vast majority of those who do receive psychoanalytic psychotherapy do so in a private practice setting and expect their medical insurance to cover the costs. It is within this context that Ann received treatment with me. Her insurance would only cover twice-weekly treatment, and at the point in the treatment described in this paper she was still very resistant to lying on the couch as it was still a fairly uncommon and unknown treatment modality. This did change later in the treatment.

REFERENCES

Craving Interpretation: A Case of Somatic Countertransference


