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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

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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 countertransferential 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 countertransferential 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

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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 related 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 fail and psychosomatic processes may thus develop.

I am suggesting that, when the countertransference is somatic, similar processes may be at work and that therapists then needs 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),

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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 analyst'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

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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 anyone 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 countertransferential response (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. Greene's work is starting to suggest the idea that, for a somatic countertransference to develop, it is a *combination* of the patient's pathology and the therapist's psyche that play a role.

In contrast, Jacobs (1973) and Stone (2006) focused their attention on researching what it is about a therapist that makes it more likely that he or she would experience countertransferences somatically. 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, the quality of the bodily experiences in the analyst's own childhood (Jacobs, 1973). What Jacobs highlights is the important role that the therapist's own history plays in the formation of somatic countertransferences.

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 incidence of the introvert–intuitive construct in these analysts. He concluded that, when the therapist resonates with the patient on the physical level, thoughts and feelings remain unknown to the conscious mind (Stone, 2006).

What the groupings of literature discussed here (i.e. locating the source of the somatic countertransference in either the patient or the therapist) have in common is that they seem to aim at a developing a general theoretical understanding of somatic countertransference. I am suggesting that to take these general concepts further it is useful to adopt a clinical approach which looks at the personal and unique dynamics of each therapeutic dyad specifically.

It is widely accepted that countertransference reactions should be worked with by the analyst, and the process for doing so would obviously be similar for all forms of countertransference, although somatic responses may require more work as they manifest in the somatic domain and need to be processed and mentalized by the analyst in order for them to enter the domain of language and thought. While the importance of interpreting countertransference reactions, whether they be somatic or otherwise, is clear and well established, countertransference reactions which the patient notices bring a further dimension to the process, which is worth exploring.

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Following the changes in the perception of the usefulness of countertransference, it became necessary to develop tools and theories so that therapeutic use could be made of countertransference reactions. A foundation for this endeavour was laid by Freud in *The Interpretation of Dreams* (1900a, 1900b) in which he explicated the process in which the analyst analyses and interprets his own internal world by means of the process of free association which was developed in order to overcome the patient's resistance and to allow the analyst access to unconscious parts of the patient's psyche (Bollas, 2002). Freud suggested that analysts are required to submit to a similar free associative process as a counterpoint to the demand placed on the patient (Freud, 1912a). In order for analysts to do this, Freud described the way in which the analyst should attend to the patient's material and which has become another fundamental tenet of psychoanalysis: free-floating attention (Lothane, 2006; Miller & Aisenstein, 2004; Parsons, 2006).

Lothane (2006) extends Freud's original concept of free-floating attention when he suggests that the analyst should not only hear what the patient says, but that he should also notice any thoughts, images, fantasies, emotions, and memories which the patient's words evoke. Making use of such a process combines the analyst's internal world with that of the patient which allows the analyst to understand the manifest content of the patient's material as well as the underlying, unconscious content. This analytic stance relates to concepts described by other writers such as Bion's (1962) 'reverie', Ogden's (2004b) 'dreaming' and Fonagy's (Fonagy & Target, 1994) 'reflectiveness' (Israelstam, 2011).

Ogden (1997a, 1997b, 2004a) has extended Bion's (1962) term 'reverie' in his discussions of therapeutic technique regarding how to make use of countertransference responses. He sees reveries not as the product of the psyche–soma of the analyst alone, but as resulting from the combined unconscious of patient and analyst. It is his view that, through the use of reverie, the analyst transforms the unprocessed material which the patient has projected into her mind, into thought (Brown, 2009). What is particularly useful about Ogden's work in this paper is his specific inclusion of the analyst's *somatic* responses in his descriptions of working to understand countertransferences.

Of interest in this paper are the particular issues that arise in the relationship when the therapist does not have the choice whether or not to disclose their understanding of, or reaction to, those dynamics. This 'decision' may be even more apparent if the psychotherapy takes place in the chair rather than on the couch. The use of the couch in psychoanalysis was designed to control the frame and the setting and to allow unconscious material to be revealed by the patient with as little influence from the analyst as possible. Sitting across from the therapist, and looking directly at them results in the therapist being much less of a '*tabula rasa*'. Face-to-face psychotherapy puts the therapist's body in a much more central role even before it may gain attention by the therapist's crying, grumbling or blushing. While the couch might provide a setting which affords the patient a greater opportunity to elaborate their fantasies about that which they do perceive, an unexpected consequence of psychotherapy taking place on this face-to-face manner is that somatic countertransferences may be

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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 therapy'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,[1] and 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.

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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 be 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

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(it was always on a Monday, the day when Ann was my last appointment of the day); the food that I was craving (a high calorie, high fat meal which I did not usually eat); the friend whom I had called (someone with whom I have a competitive relationship, and it seemed that I had unconsciously tried to mitigate my failure by making my friend complicit in it, in order to defend myself from feeling defeated by my patient and envious of her iron will) and the thought which had occurred to me 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 know myself to be compelled to do 'difficult' things and to enjoy the success achieved in completing difficult tasks, but what was being activated in this transference–countertransference experience was a feeling that the patient triumphed over me because she was able to resist the temptation and do the 'difficult' thing of not eating. She was able to walk away from the meat pies, but I had eaten the meaty pizza. I felt that I was not as 'strong' as she was and knew that the patient would certainly not have 'given in' or 'caved' as I had done since she would simply never eat a pizza, much less a meaty one. Recognizing Ann's competitiveness and seeing how it was disavowed, but present in a disguised form, in her sweet but patronising manner I could then see how her minding of my body in the form of her comments about the borborygmi (as well as her comments about session start times) had lured the competitiveness in me. It was her reaction to that which was perceivable in me which became a crucial trigger to my understanding of the therapy dynamics.

I became aware, however, of a paradox in the win–lose competition with Ann. My enactment which took the form of calling my friend and eating the pizza meant that I had 'lost' the competition of control over bodily urges, but, in eating, I also allowed myself to be healthy and not trapped in the anorexic web that Ann found herself in. While I initially felt shamed and defeated, it was through that creative act (Rosenberg, 2006) of understanding the countertransference and putting it into words (if only to myself) that my interpretive capacity was re-established and my therapeutic role retrieved. Holding the physical response in mind, noting the moments in which it appeared and trying to link it to specific material that the patient brought facilitated the metabolizing and mentalizing of my physical experience. The consequently improved understanding of the patient's unacknowledged competitiveness sharpened my focus on this issue. Listening for such material it was then possible for us to start talking about the competitiveness in her relationships which allowed her access to a part of herself that she had, until that point, not allowed herself to acknowledge. As Ann became more consciously aware of her competitive nature, she began to engage differently with those in her world. At that point my countertransference no longer took a somatic form.

On reflection, it was clear that there had been a two-stage process involved in the interpretation of my somatic countertransference. Ann's comments on my stomach sounds and my experience of the accompanying craving drew my attention, firstly, to the form of my response and thus to the ideas of eating, the desire for food, and, most importantly, control over that desire. Importantly, however, my reverie made it clear

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that the physical response was occurring in relation to her. Enacting those cravings allowed me to then mentalize the deeper, more unconscious dynamic of competition between us, which in turn allowed me to return the dissociated parts of Ann that I had identified with back into the dyadic space where it could then be interpreted and processed (Bromberg, 2003a).

DISCUSSION

I will reflect on this case material by discussing three issues. The first is a rehearsal of the existing literature specifically the literature concerned with the origin of the somatic countertransference and that on borborygmi in particular. The second point to be discussed is the use of reverie in the interpretation of somatic countertransference. The final area of focus is the specific concerns brought to the therapy when the therapist's somatic countertransference is perceivable by the patient.

In order to make sense of the transference–countertransference dynamics at work in the case of Ann, it was necessary to establish why this response was occurring with this particular patient at this particular point in the therapy. The patient, Ann, did have some borderline defences which were identified by McLaughlin (1975) as being involved in the development of somatic countertransferences. She was also eating disordered which Samuels (1985) recognized as a potential factor in the development of a somatic countertransference. These points were helpful in developing some thoughts around what it was about Ann that was triggering this response in me. It was important to note, however, that I treat a number of eating disordered patients with borderline defences, and while it is well known that countertransferences with patients with that combination of pathologies are often very intense (Russell & Marsden, 1998), the physical response in question occurred with only this patient. It followed that attention should also be given to what it might have been about me that might have been activated by the patient, as Stone (2006) and Jacobs (1973) suggested. It was evident that I did contribute something general to the relationship with my patient (i.e. my competitiveness), but although that is a stable part of me, competitiveness was a part of *this* therapy and does not occur with all my patients. It is then clear that while there were aspects of both the patient's pathology and the therapist's personality which had played a role in the developing of the somatic response to the patient, it was the interaction of all the relevant elements of the therapeutic dyad which were required for the somatic countertransference to be produced in the form in which it manifested. Bromberg (1996) explains how dissociations function interpersonally in the therapeutic dyad and form a power and multifaceted channel of communication that is separate to the verbal one. Much of the work with Ann involved my attempts to understand what she had dissociated and which I was enacting.

Da Silva (1990) and King (2011) have written about the physical response of borborygmi specifically. This literature establishes the idea of gastro-intestinal movements as having a strongly metaphoric dimension and thus the authors suggest that

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they hold a psychic meaning, and consequently link body and mind. Instantiated in the case of Ann, it was clear that this particular understanding of gastro-intestinal responses allowed me to enter the site at which her pathology (anorexia) played itself out and was evidence of the desires that she dissociated herself from, but that this was merely the arena in which our competition occurred. With Ann, the form of the somatic countertransference was a clue to the final understanding, but was 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 form of somatic countertransference and how the body of the analyst can become treated as an object of transference activity in unique ways in each individual therapeutic relationship.

In this case, my borborygmi was 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 to hang between Ann and myself emphasized the physicality of the countertransference: it was not a vague wish for some sort of food, but instead I had visually and specifically conjured up the precise object which I desired in a very physical way. There are of course limits to the form of satisfaction that fantasy can provide which is why hallucinatory satisfaction is partial, and my hunger persisted. Only my enactment of actually ordering and eating the pizza satisfied the craving.

In order to explore the meaning of my countertransference and the manner in which it manifested, Ogden's writings on reverie were very useful in developing an understanding of what was at work in this case. Four points arose from Ogden's extensive writings on the subject of the analytic use of reverie that were especially useful. The first of these points is that working with, and interpreting, reverie transforms unconscious, intersubjective experiences into verbal metaphors which are then accessible to the analyst. From a position of free-floating attention and reverie in the treatment with Ann, it became possible to track the associations and follow the links in order to move them from the physical response of stomach rumbling into a more mentalized space where it became possible to begin to reflect on what was being played out on the level of hunger and the control of physical desires.

The second point made by Ogden (Ogden, 1996a, 1996b, 1997a) which was helpful here is that the content of a reverie needs to be interpreted and understood rather than simply shared concretely with the patient, because doing so will lead to superficial interpretations in which manifest content may be mistaken for latent content. This point was particularly helpful in the described case as it ensured that the understanding of the dynamics at work moved from the first level which focused on food and eating, to a second deeper, more unconscious level which revealed the dynamics of competition.

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 distresses, physical state or personality. Every situation experienced by an analyst is framed differently in the face of each patient and thus becomes a different

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'analytic object' in each therapy. As described in the case with Ann, it was her comments and the manner in which they were delivered which brought the dynamics between her and me to life. Reflecting on the way in which Ann presented and engaged in therapy – superficially very sweetly, but always a little critical and patronizing – allowed me to develop an understanding about what role was being played in my countertransferential response to her. Thus Ann's way of engaging with her therapist brought out something in her therapist which revealed something about Ann.

The final of Ogden's (1994a, 2004a, 2004b) points made use of in understanding this case was his idea that it is not helpful to discuss the highly personal emotional experience that is reverie with the analysand directly. It should first be made sense of in terms of the patient's material and the analytic relationship. In the case of Ann it would not have been helpful to simply reveal the craving, hallucination and enactment to Ann. It was far more important that the work of understanding how all the elements fitted together and what they revealed needed to be done first, and then for that digested understanding to be used effectively in the therapy room.

The contribution that I am attempting to make here is the idea that the analytic use of reverie is a process which facilitates the analyst's mental process of that which was originally physical. Ogden's suggestion that the contents of the therapist's mind are as important as the responses in their bodies (Ogden, 1997a), in the process of reflecting on and making use of reverie, is particularly helpful in this regard. Clearly, unmentalized material is often present in a treatment, and when a patient is not able to express their internal conflicts in words, their preverbal transference may instead be manifested in the analyst's countertransference (Jacobs, 2001; Richards, 1989). The point at which the 'unmental' become sufficiently accessible to the conscious mind is the moment it becomes possible to use that material in the talking cure. The first signs of this process in this case were the rumblings in my stomach. Reverie was then useful to render coherent the thoughts, physical sensations and the wandering of my mind, thus giving the bodily and the mental due and equal attention which eventually allowed for significant therapeutic gains to be made.

Despite the volume of literature that discusses countertransference generally, there is relatively little written on the technique of exactly how interpret and work with it. The work of Ogden is very significant in that regard for this paper as his examples do not only explicate the process of using reverie (see, for example, Ogden, 1994a), but the notion of reverie and the affective overtones as used by Ogden seem to have a particular applicability to somatic countertransferences precisely because they allowed me make associations to responses that were not as yet in the medium of words (Ogden, 1994a, 1997a). This paper is arguing that drawing attention to the physical aspects of reverie allows the analyst to reflect on, and in that way mentalize, their somatic responses eventually enabling them to interpret their somatic countertransference.

An important issue raised by the case of Ann is the complexity brought to the therapy room when the therapist's somatic countertransference response to the patient is perceivable by the patient. Somatic countertransferences in general are often more difficult to make sense of than those which occur in other domains because they need to be translated from the language of the body to the language of the mind. An extra

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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 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 countertransferential 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

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domain of thought or fantasy can be kept from the patient and remain in the therapist's reverie 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 transference–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.

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